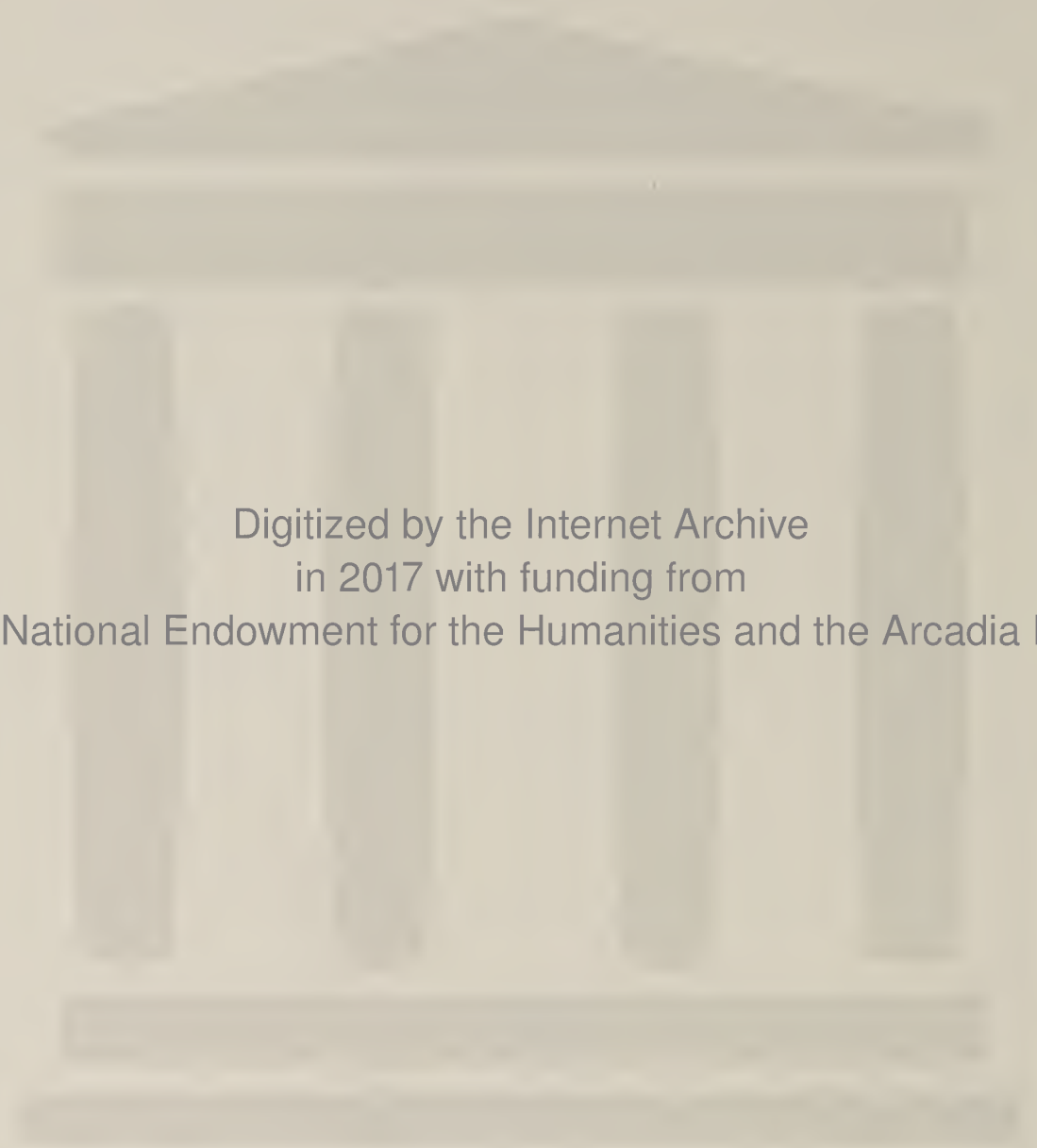
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VOLUME 96, NUMBER 1 JANUARY 1998

SCIENTIFIC

Gelatinous Transformation of Bone Marrow 10
Alan Shultz, MD; Lung T. Yam, MD

Anorexia and Failure to Grow Associated with Epstein-Barr Virus Infection 13
Michael W. Simon, MD, PhD

SPECIAL ARTICLES

Mobile Mammography Screening: The James Graham Brown Cancer Center Three Year Experience — Implications for Public and Professional Education 17
Michael B. Flynn, MD; Elizabeth A. Amin, MD; Robert C. G. Martin, II, MD

EDITORIAL

Webster's New Edition 21
Carolyn D. Burns, MD

ASSOCIATION

Monitoring Medicine 7
KMA 1998 Legislative Seminar 6
AMA Article — Physician Impairment and Health: A Brief Overview, by Larry S. Goldman, MD 25
Reference Cominittee G — AMA Annual Meeting 28
Committee on Medicaid Managed Care 29
News 30

DEPARTMENTS

President's Page 5
Advertisers' Guide 34
Alliance Page 23
Classified 33
Information for Authors 15



COVER:
Kentucky's Capitol is one of the hondsomest statehauses in America. It is mognificent in total effect yet plain and classic in its lines. Visitors will note much French influence in the building. The rotundo and interiar af the dame, ond the lontern ond dame exteriar, were capied from the Hotel des Invalides aver Napaleon's tomb in Poris.

***Lee Wode of Eminence, Kentucky hos vividly coptured the beauty af the Capital an o blustery, snowy day, much like o day one might encaunter when visiting Fronkfort far the Legislative Session. Ta fomiliarize you with the Generol Assembly prior to your visit, enclosed with this issue is the* 1998 KMA Legislative Hondbook.**

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What Will Be Your Priorities This Winter?



Wally O. Montgomery, MD

As you read this article, the Kentucky General Assembly will be in session and many bills will have been introduced. Leadership of the Senate and House have reappointed several committees which appear to be more in accord with the Democrat-Republican ratio. Committees are meeting on a daily basis. However, few bills will have been discussed, and nothing of significance passed. Action rarely occurs until the candidate filing deadline for 100 Representatives' seats and 19 of 36 Senators' positions is past, which occurs later this month. Whether or not a legislator has serious opposition can be a determining factor as to how they react to legislative proposals.

Since the 1996 Session, we have had Special Sessions on Worker's Comp, Education Reform, and Health Insurance Reform. Health Insurance Reform was the only legislation that failed to pass. It is my prediction that health insurance legislation, similar to bills introduced during the Special Session, will be reintroduced, debated throughout the Session, but not voted on until late March. Don't be surprised if this is the last bill voted on — the last night of the Session.

Kentucky Medical Association's primary agenda includes reintroducing the patient protection provisions with hope and anticipation that they will be passed. During the Special Session, we found little opposition to patient protection measures formulated over a period of years on the AMA as well as the KMA level. Patient Protection has been considered on many occasions by the KMA House of Delegates.

Once again, we will see many legislative proposals introduced related to health, safety, substance abuse and domestic violence. Tort reform will continue to be a priority for KMA this session. Unfortunately, we do not anticipate passage of any legislation of any significant benefit to physicians. However, we will continue our efforts in this area.

Be assured, though, that non-physician providers will be back at the trough trying to enhance their practice acts and mandate insurance coverage for treating our patients. Whether they are capable or trained to perform such care is always secondary when it can be obtained through "legislative fiat." Being cognitive of their efforts is a never ending task for KMA.

Many other bills will be introduced. In fact, I would be surprised if we do not have at least 200 bills which relate to the practice of medicine. Our lobbyists and the Quick Action Committee will be carefully reading these bills, and developing positions that adhere to House of Delegates directives.

Now back to the original question. What do you plan to be doing this winter? Later this month, on the 28th of January, KMA will sponsor a Legislative Conference in Frankfort at the Capital Plaza Hotel. Registration, materials, and meals are free to members and spouses, provided you pre-register. We have invited the Governor, Secretary of CHS, Insurance Commissioner, and leadership of the General Assembly to speak. I invite each of you to attend. It is always encouraging to those of us who find ourselves in Frankfort on a weekly basis to have other physicians visit Frankfort, taking part in talking to their Senators and Representatives, and learning about the legislative process. Please join us and make the trip to Frankfort. Play your part in making this a successful session of the Kentucky General Assembly.

Wally O. Montgomery, MD, FACS
Chair, State Legislative Committee

1998 KMA LEGISLATIVE SEMINAR
JANUARY 28, 1998
CAPITAL PLAZA HOTEL
FRANKFORT, KENTUCKY

	C. Kenneth Peters, MD, President, Presiding
8:00 to 8:30	Continental Breakfast
8:30 to 9:00	Governor Paul E. Patton ***State of the Commonwealth***
	Donald R. Stephens, MD, President-Elect, Presiding
9:00 to 9:20	Senator Dan Kelly, Senate Minority Floor Leader ***The 1998 Session - The Minority Party Perspective***
9:20 to 9:40	Representative Jody Richards, Speaker of the House ***The 1998 Session - The Speaker's Perspective***
9:40 to 10:00	Senator Larry L. Saunders, President of the Senate ***The 1998 Session-The President's Perspective***
10:00 to 10:15	BREAK
	William P. VonderHaar, MD, Secretary-Treasurer, Presiding
10:15 to 10:45	Mr. George Nichols, Commissioner, Department of Insurance ***Health Insurance Reform***
10:45 to 11:00	Representative Bob M. DeWeese, MD ***Health Care Legislative Priorities in 1998***
11:00 to 11:15	William B. Monnig, MD, KEMPAC Chairman ***Political Realities***
11:15 to 11:45	Wally O. Montgomery, MD Chair, Committee on State Legislative Activities ***KMA's Legislative Agenda***
11:45 to 12:00	Mrs. Angie DeWeese, Vice President, KMAA ***Alliance Priorities and Programs for the 1998 Session***
	J. Gregory Cooper, MD, Chair, Board of Trustees, Presiding
12:00 to 12:30	LUNCH
12:30 to 1:00	Mr. John H. Morse Secretary, Cabinet for Health Services ***Medicaid Partnerships, CON, and Health Departments***
1:00 to 1:10	Preston P. Nunnelley, MD Vice Chair, Committee on State Legislative Activities ***Lobbying Is A Contact Sport***

REGISTRATION IS FREE FOR PHYSICIANS, SPOUSES, AND OFFICE STAFF. HOWEVER, YOU MUST PRE-REGISTER BY CALLING (502) 426-6200.

NEWS FOR KENTUCKY PHYSICIANS
THE 1998 MEDICARE PHYSICIAN FEE SCHEDULE

On October 31, 1997, the Health Care Financing Administration (HCFA) published in the *Federal Register* the 1998 Medicare Fee Schedule (MFS) for physician services. This final rule indicates HCFA's decisions on policies described in its proposed rule of June 18, 1997, provides implementing regulations for Balanced Budget Act (BBA) provisions, and proposes interim relative values for new and revised CPT codes for 1998. Comments on the rule are due by December 30, 1997. The 1998 MFS is effective January 1, 1998. Highlights of the rule are as follows:

Conversion Factor: The BBA establishes a single conversion factor effective in 1998, replacing the previous three conversion factors. The 1998 single conversion factor will be $36.69, which provides an increase of 8.4% for the 54% of Medicare services that were previously on the non-surgery, non-primary care conversion factor. The conversion factor represents a 2.6% increase from the 1997 primary care conversion factor and a 10.4% decrease from the surgery conversion factor.

Specialty Impacts: Specialty impacts for 1998 are driven by a combination of the conversion factor and relative value changes, and reflect the average mix of services each specialty provides. lmpacts on surgical specialties range from an increase for otolaryngology of 0.5% to a decrease of 8.8% for cardiac surgeons, with general surgery at −2.3% and plastic surgery at −5.3%. Family physicians will see increases of 6.4%, gastroenterologists' payments will increase 7.1%, and diagnostic radiology payments will increase 8.2%.

Global Surgery: The AMA/Specialty Society RVS Update Committee (RUC) recommended that the physician work relative values for postoperative hospital and office visits be increased to reflect the increases for individually reported visit services from the 5-year review. The final rule implements the RUC's recommendation, providing 4%–7% increases in the work values for most surgical procedures.

RUC Recommendations: HCFA has accepted a record 96% of the RUC's recommendations on the work values for 208 new and revised codes for 1998. Coding changes addressed by the RUC include new codes for hip arthroscopy, laparoscopic surgery, and discharge day management, and revisions in the home visit codes.

Practice Expense Notice and Comment: Responding to the BBA provisions and the AMA's call for more opportunity for public comment on resource-based practice expenses. HCFA has published a notice with a 60-day comment period seeking information on: generally accepted cost accounting principles, cost accounting studies of physician practices or specialties, equipment utilization and prices, indirect costs, site-of-service assumptions, use of physician-employed staff in hospitals, and the refinement process to be used during each of the 4 years of the transition. The notice is in line with BBA requirements advocated by the AMA that HCFA use data on physicians actual practice expenses to develop the new resource-based practice expense relative values.

1998 Practice Expense Adjustment: The rule explains the BBA provision for a special adjustment to the practice expense relative values for 1998. Final HCFA calculations of the "down-payment" effects found that reducing the ratio of practice expense to physician work values to no more than 110% would reduce payments for procedures by $330 million and provide an increase in the practice expense values for office visits of 13%.

Multiple Procedure Rules: HCFA's June practice expense proposal had included a policy change that would extend to office services the payment reductions for multiple procedures that are currently applied to surgical procedures. The AMA and many specialties had strongly opposed this change. HCFA has deferred consideration of this issue along with the other practice expense issues, so the multiple procedure policy is not being implemented in 1998.

Actual Charges: The AMA and many specialties had also strongly opposed HCFA's proposal to establish payments in certain circumstances at the lessor of the MFS amount or the

lower amount that physicians had agreed to accept in contracts with non-Medicare payers, with this lower amount redefined to be the physician's "actual charge." The final rule withdraws this proposal from its scheduled 1998 implementation, but indicates that HCFA still believes the underlying principle is correct, suggesting advocacy efforts on this issue must continue. The AMA is also addressing a similar proposal referencing "usual" rather than "actual" charges which has been issued by the Inspector General.

Preventive Medicine Services: Effective January 1, 1998, the BBA provides Medicare coverage of colorectal cancer screening, cervical and vaginal cancer screening, bone mass measurement (effective July 1998), and diabetes self-management training. The rule describes HCFA's consultation with a physician panel convened by the AMA and the regulations on coding, payment, indicators of high risk, covered screening tests, and frequency of screening are generally consistent with this panel's suggestions. Although the rule notes the importance of preventive counseling in conjunction with preventive screening; however, it provides no guidance on coding and payment for such counseling.

Diagnostic Tests: HCFA had proposed establishing three levels of physician supervision of diagnostic tests — general, direct, and personal — indicating a range of attention required by the physician, from providing overall direction and control without necessarily being present up to being physically present in the room where the test is being done throughout the performance of the test. The AMA had questioned the rationale for this proposal and commented that unless HCFA clearly informed physicians which level of supervision was required for each type of test, this rule could lead to a situation similar to the physicians at teaching hospitals (PATH) audits. The final rule significantly clarifies the reasons for the supervision requirements and provides a list showing the level of supervision required for the technical component of each diagnostic test.

GPCI Update: HCFA is required to update the geographic practice cost indices (GPCIs) every three years and the rule provides the updated GPCIs for 1998-2000. An AMA analysis found the new GPCIs change very little, although they do incorporate more recent data on professional liability insurance premium and rental costs.

1998 SGR: The BBA established a sustainable growth rate (SGR) system to control Medicare expenditure growth, which replaces the previous Medicare Volume Performance Standard (MVPS). Our initial impression is that HCFA's establishment of the 1998 SGR at 1.5% is a significant improvement over what the 1998 MVPS likely would have been. A more complete AMA analysis of the SGR became available in December.

This information was provided by the American Medical Association.

It's time to reform Medicare. But please...



Be fair about it.

We all recognize the need to bring Medicare spending under control.

But what's the fairest way to do it?

Some people in Congress are advocating deep cuts in reimbursements to physicians. That's one way to cut costs. But is it fair? And, more importantly, will it really reform Medicare?

Some very influential voices in government and the press don't think so. Here's a sampling of what they say:

Congressional Budget Office: In a 1996 report on deficit reduction, the CBO warned that with across-the-board cutting in Medicare, some beneficiaries "*...might find that they no longer had access to some medical services in the traditional fee for service sector.*"

The New York Times: In an editorial, the *Times* criticized policy makers who "*...pretend that physician reimbursements can be cut without affecting health care—as if both doctors and hospitals can be slammed without hurting anyone except the providers of care.*"

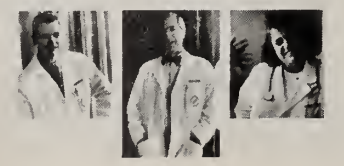
Physician Payment Review Commission: In its annual report to Congress, PPRC said the current Medicare reimbursement formula for physicians "*...will set increasingly unrealistic target rates of expenditure growth....*"

Physician cuts alone will not do the job. And the cuts that are currently proposed would actually hurt physicians by rolling back reimbursements so far that they don't even match inflation growth.

That's not fair. It's not fair to physicians, and it's not fair to patients, who ultimately pay the price under such drastic cuts.

What we need is real reform. Real reforms will offset the need for deep, unfair cuts to physicians. The American Medical Association has a plan for reform that offers fiscal stability, expanded choices for patients, a new system of funding graduate medical education, and, above all, fairness.

To learn more about our plan, call 1-888-AMA-1997.



TODAY'S AMA
Giving Power To Your Voice

Gelatinous Transformation of Bone Marrow

Alan Shultz, MD; Lung T. Yam, MD

From the Veterons Affoirs Medicol Center, Louisville, KY. Supparted in part by the office of Research ond Development of the Department of Veterons Affoirs, Woshington, DC.

We present herein a patient with multiple medical illnesses, marked weight loss, and chronic anemia. Cytologic studies of his bone marrow revealed hypocellularity and gelatinous transformation (GTBM). The latter is a disorder of the hematopoietic system commonly occurring in chronically ill patients and is associated with various hematologic abnormalities. The etiology of GTBM is uncertain. Patients with this disorder may have associated medical problems but malnutrition seems to play a role. Review of the literature implies a significant associated morbidity and mortality, and a possible reversal of gelatinous changes with intense nutritional support. An otherwise dismal prognosis may be avoided by prompt diagnosis of this disorder and intensive nutritional support.

Gelatinous transformation of the bone marrow (GTBM) is a recognized, albeit a poorly understood, disorder of the hematopoietic system. It has been associated with many diseases including anorexia nervosa[1] and intensive care unit patients.[2] Frequently there are cytopenias and a diminished granulocyte reserve.[2,3] The bone marrow is often hypoplastic with fat atrophy and accumulation of a gelatinous material which is rich in hyaluronic acid. To date, there are no accepted treatments for GTBM and its presence may signify poor prognosis. The etiology of GTBM is uncertain but malnutrition seems to play a role. Recognition of this disorder depends on clinical awareness of its existence and knowledge of its characteristic features. The clinical suspicion is confirmed by proper studies of the bone marrow. Herein we report a patient with the typical features of GTBM and describe the clinical characteristics and findings in the bone marrow.

Case Report

The patient is a 73-year-old white male admitted to the Veterans Affairs Medical Center in Louisville for evaluation of chronic anemia and possible intravenous iron therapy. He had a past medical history of a partial gastrectomy with Bilroth ll, left hemicolectomy secondary to ischemic bowel, rheumatoid arthritis, vitamin B_{12} deficiency, and anemia of chronic disease. The patient complained of long-standing lethargy and weakness. In addition, he stated he was unable to tolerate oral iron therapy due to gastrointestinal upset. Physical examination showed that he was cachectic, weighed 90 lbs and was 71 inches tall. He exhibited bi-temporal wasting and general muscle atrophy. He had no signs of active synovitis, hepatosplenomegaly, or lymphadenopathy. Results of laboratory studies included an albumin of 3.3 g/dl, globulin of 3.1 g/dl, and cholesterol of 178 mg/dl. The remainder of his chemistries were normal. A complete blood count revealed a leukocyte count of 6,800/mm^3, hemoglobin of 7.0 g/dl with a mean corpuscular volume of 69.9, and mean corpuscular hemoglobin concentration of 30.7. The leukocyte differential and platelet counts were normal. The sternal aspirate had a "slimy" consistency and contained many marrow spicules. Microscopic examination of air-dried smears of the aspirate revealed marked hypocellularity of hematopoietic cells, fat atrophy, and accumulation of an amorphous, pink-staining, extracellular material. No stainable iron was present (Fig 1). The patient was treated with parenteral iron therapy, but refused any further work-up. He has been followed by his primary care physician since his discharge and repeat studies have shown a persistence of his anemia.

Discussion

Gelatinous transformation of the bone marrow is a cellular deficiency in the bone marrow characterized by the accumulation of a gelatinous material which is an acid mucopolysaccharide and is rich in hyaluronic acid. This disorder can be associated with many different diseases (Table 1).[1,2,4-9,12,13] Patients typically have chronic underlying

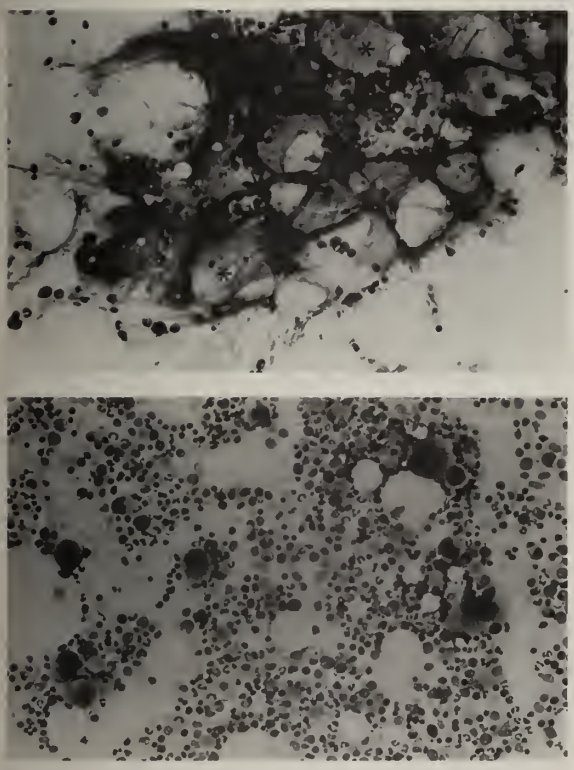


Fig 1 — A. Smears of marrow aspirate showing severe hypocellularity, atrophy of marrow fat and an accumulation of homogeneous, eosinophilic staining gelatinous material (asterisks). This material surrounds fat spaces and focally replaces hematopoietic elements. B. Smears of normal marrow aspirate showing normal cellularity, cell:fat ratio, and absence of gelatinous material. (Wright giemsa stain × 240)

medical conditions and a thorough history often reveals poor appetite and weight loss. They are markedly cachectic and ill-appearing. Laboratory studies may show a low cholesterol.[1] Often, hematologic abnormalities are present and represent the only laboratory abnormalities. The diagnosis is based on a clinical suspicion of its presence and confirmed by proper bone marrow studies.

The prevalence of GTBM is not known. There are multiple reports of its presence in anorexia nervosa.[1,6,7,12] It has been reported in 13 of 24 intensive care unit patients studied in one center,[2] nine out of 210 consecutive autopsies at the Veterans Hospital in Salt Lake City,[4] 29% of 75 patients with acquired immunodeficiency syndrome (AIDS),[5] and 3 of 30 systemic lupus erythematosus (SLE) patients with pancytopenia.[8] The etiology of GTBM is not completely understood. In one study, all affected patients had significant weight loss and were cachectic.[4] Interestingly, when such patients were matched with a control group with similar degrees of weight loss and cachexia, no GTBM was found in the control group.[4] Additional case reports describe this disorder in association with SLE[8] and leishmaniasis,[9] and in each patient a history of weight loss and decreased appetite was noted. Intense nutritional support in patients with anorexia nervosa and GTBM has been reported to reverse gelatinous changes.[7] These findings implicate a multifactorial etiology, yet the final common denominator appears to be malnutrition.

The clinical significance of GTBM is not known. As with our patient, cytopenias are often present. Anemia is the most common finding;[1] however diminished granulocyte reserve has been reported.[2,3] Patients with AIDS and GTBM have an increased prevalence of mycobacterium avium-intracellulare.[5] In Intensive Care Unit patients, persistence of hypocellularity on repeat bone marrow biopsy was associated with 100% mortality.[2] Certainly, an association with increased morbidity and mortality is implied. This may represent a diminished capacity to respond to blood loss or infection secondary to a limited bone marrow reserve. Ultimately, patients with this disorder are already compromised and an inability to respond adequately to stress may be fatal.

Table 1. Associated Diseases in Gelatinous Transformation of Bone Marrow

Neuropsychiatric
Anorexia Nervosa[1,6,7]
Obsessive Compulsive Disorder[4]
Parkinson's Disease[13]
Huntington's Chorea[4]
Endocrine/Metabolic
Graves Disease[12]
Hypothyroidism[12]
Chronic Renal Failure[12]
Infectious
Chronic Bronchitis[4]
Leishmoniasis[9]
Tuberculosis[12]
Acquired Immunodeficiency Syndrome[5]
Inflammatory
Systemic Lupus Erythematosus[8]
Ulcerative Colitis[12]
Others
Pernicious Anemia[4]
Critically Ill Patients (Intensive Care Unit)[2]
Malignancies[4]

Identifying patients with this disorder requires an index of suspicion based on clinical characteristics and a thorough cytologic examination of the marrow aspirate or histological assessment of the marrow biopsy. In smears of aspirate stained with Wright-Giemsa, the characteristic finding is the presence of amorphous, extracellular, pink-staining material surrounding fat spaces, or in more severe cases, replacing hematopoietic cells, as was the case in our patient. This substance has been recognized as acid mucopolysaccharide which is rich in hyaluronic acid.[4] Its presence is the *sine qua non* of GTBM. In sections of marrow biopsy stained with hematoxylin-eosin, the findings would include fat atrophy. The fat cells become smaller and the spaces between the fat cells are filled with a slightly homogeneous, eosinophilic substance. This material can be better visualized with Giemsa stain, Toluidine Blue or Alcian blue, or a Periodic Acid Schiff stain. The extent of marrow involvement can be assessed by nuclear bone scan or magnetic resonance imaging.[10]

In conclusion, GTBM is more common in chronically ill patients than previously thought. Its presence usually denotes significant nutritional deprivation. Although specific and universally effective treatment is presently unavailable, GTBM may be reversible in some patients. An otherwise dismal prognosis may be avoided by prompt diagnosis of this disorder and intensive nutritional support.

References

1. Mant MJ, Faragher BS. The hematology of anorexia nervosa. *Br J Haematol.* 1972;23:737-749.
2. Amos RJ, Deane M, Ferguson C, Jeffries G, Hinds CJ, Amess JAL. Observations on the haemopoietic response to critical illness. *J Clin Pathol.* 1990;43:850-856.
3. Pearson HA. Marrow hypoplasia in anorexia nervosa. *J Pediatr.* 1967;71:211-215.
4. Seaman JP, Kjeldsberg CR, Linker A. Gelatinous transformation of the bone marrow. *Hum Pathol.* 1978;9(6):685-692.
5. Mehta K, Gascon P, Robboy S. The gelatinous bone marrow (serous atrophy) in patients with acquired immunodeficiency syndrome. *Arch Pathol Lab Med.* 1992;116:504-508.
6. Bailly D, Lambin I, Garzon G, Parquet PJ. Bone marrow hypoplasia in anorexia nervosa: A case report. *Int J Eating Disorders.* 1994;16(1):97-100.
7. Steinberg SE, Nasraway S, Peterson L. Reversal of severe serous atrophy of the bone marrow in anorexia nervosa. *J Parenter Enteral Nutrition.* 1987;11(4):422-423.
8. Margaret HL, Edmund NG, Li K, Chi-Shun F. Gelatinous transformation of bone marrow in systemic lupus erythematosus. *J Rheumatol.* 1989;16:989-992.
9. Varma N, Bhoria U, Bambery P, Dash S. Gelatinous transformation of the bone marrow and *Leishmania donovani* infection. *J Trop Med Hyg.* 1991;94:310-312.
10. Vande Berg BC, Malghem J, Devuyst O, Maldague BE, Lambert MJ. Anorexia nervosa: Correlation between MR appearance of bone marrow and severity of disease. *Radiology.* 1994;93:859-864.
11. Savaga RA, Sipple C. Marrow myxedema. *Arch Pathol Lab Med.* 1987;111:375-377.
12. Tavassoli M, Eastlund T, Yam LT, Neiman RS. Gelatinous transformation of the bone marrow in prolonged self induced starvation. *Scan J Haemotol.* 1976;16:311-319.
13. Cornbleet PJ, Noir RC, Wolf PL. A histochemical study of bone marrow hypoplasia in anorexia nervosa. *Virchow Arch.* 1977;9:685-692.
14. Smith RRL, Spivak JL. Marrow cell necrosis in anorexia nervosa and unvoluntary starvation. *Br J Haemat.* 1985;60:525-530.

Anorexia and Failure to Grow Associated with Epstein-Barr Virus Infection

Michael W. Simon, MD, PhD

The Epstein-Barr virus is a common cause of contagious disease in childhood. It may produce fever and sore throat in young children and infectious mononucleosis in teenagers and young adults. This report discusses four cases of children with anorexia and poor weight gain due to Epstein-Barr virus infection.

Failure to grow is an important manifestation of childhood illness.[1] Organic and psychological disorders may produce failure to grow and anorexia. A brief loss of appetite may occur during any acute infection.[2] There may be a uniform refusal of all foods.[3] This may be severe enough to cause no or poor weight gain or actually produce weight loss.

The Epstein-Barr virus produces a variety of symptoms including fever and sore throat in young children, as well as infectious mononucleosis in teenagers and young adults.[4] It may be associated with apnea of infancy.[5] In this report the cases of four children with disinterest in eating and poor weight gain or weight loss associated with Epstein-Barr virus illness are discussed.

Case Reports

Case 1 — A 16-month-old white male in a state of good health presented with fever of 38.5°C, cough, sore throat, and runny nose. Physical examination showed a red throat with clear rhinitis, swollen cervical nodes, and thick post nasal drip. He was treated with Cefprozil and symptomatic measures. He returned 9 days later with no improvement, green nasal drainage, cough, fever, and a weight of 22 lbs and 8 oz. A CBC had a WBC of 7,300, HCT 38%, platelet 400,000, 55% neutrophils, 2% bands, 38% lymphocytes, 2% monocytes, and 3% eosinophils.

He continued the previous measures. Three days later he was reported to have disinterest in feeding and fever of 39.5°C. The symptomatic measures were continued. The following day he was reevaluated. The weight was noted to be 22 lbs 2½ oz and fever 39.5°C. He was playful and did not appear ill. Examination showed a red throat and cervical adenopathy. No changes were made in his management. An EBV profile was drawn and shown to be positive for convalescent stage illness with positive VCA-IgG and nuclear antigen antibody. His mother showed serologic evidence of previous EBV illness.

He seemed to slowly improve and feel better. One week later he had recurrence of fever of 39.5C and a convulsion. His weight was 23 lbs at that time. Examination revealed a red throat, post nasal drip, and injection to both tympanic membranes. A CBC had a WBC of 6,700, HCT 40%, and platelet count of 583,000. The differential had 64% neutrophils, 12% bands, 15% lymphocytes, and 9% monocytes. He received Rocephin 50 mg/kg IM. Within 2 days he was again improved. At return follow-up he was doing well and continues to thrive at his well child visits.

Case 2 — A 6-month-old white male presented with fever 39.5°C, and irritability. Examination showed exudative pharyngitis, upper airway congestion, and injection to the right tympanic membrane. He was treated with Erythromycin-Sulfisoxazole and Ibuprofen. The child was re-evaluated 2 weeks later and found to be irritable with a fever of 39°C. He was feeding poorly. Exam showed upper airway congestion, bilateral serous otitis, and purulent nasal drainage. His weight was reported at 15 lbs 6 oz. He was treated with Cefprozil. Three days later he was re-evaluated and his weight measured to be 15 lbs. He was found to

be irritable and not resting well. The family reported that the child was feeding poorly, taking only 3 ounces per feeding. He looked wasted with loss of subcutaneous fat. He was having one formed stool per day. The WBC was 13,300, HCT 36%, and platelet count was 173,000. The differential had 18% neutrophils, 2% monocytes, 75% lymphocytes, with 5% atypical lymphocytes noted. Over the next 2 week period he fed better and gained 8 oz. Then he dramatically cut back to a total of 16 oz a day. EBV profile was assayed and found to be negative. A repeat profile 10 days later was found to be positive for VCA lgM and VCA lgG. His mother had a negative serologic profile. The feeding slowly improved and the child gained weight over the next 2 month period. He continues to do well at routine well child follow-up.

Case 3 — A 5-month-old presented with poor feeding. He had an unremarkable prenatal and birth history. There were no family problems or stress reported. There was a documented 8 oz weight loss in the preceding 31 day period. He had lost interest in feeding and would take 15 oz of formula per day. The child had recurrent oral and diaper yeast infection. The infection poorly responded to Nystatin and Ketoconazole. Physical exam showed red throat with white cheesy material on the buccal mucosa and red confluent diaper rash with satellite lesions.

Hospital admission was coordinated for further treatment and to evaluate infant-mother interaction. A screening CBC had a WBC of 17,400, HCT 36%, and platelet count of 508,000. The differential had 10% neutrophils, 80% lymphocytes, 6% monocytes, 3% eosinophils, and 1% basophils. SMA 24 and urinalysis were normal. QlGs were normal for age. Urine metabolic screen for amino acids and organic acids was non-diagnostic. An EBV profile was positive for VCA lgG and EBV NA. These titers were negative for the mother. The infant was diagnosed with convalescent phase EBV illness.

He was discharged on calorie enhanced formula at 26 cal/oz. He has improved and his feeding and weight gain have placed him around the 50th%. No additional yeast problems have occurred. He continues to grow and develop well at routine follow-up.

Case 4 — A 10-week-old male presented with a several day history of not breastfeeding well. He had an unremarkable prenatal, birth, and neonatal course, having been born at 42 weeks of gestation and weighing 8 lbs 6 oz. The interim history had been normal. The family was healthy and no social changes had occurred since the infant's birth.

The day of presentation he had a normal examination. His weight was noted to be 12 lbs 8 oz. The mother was given supportive assistance. She was encouraged to continue breastfeeding and give supplemental formula. Two days later the child returned with progressively worse feeding. His weight was recorded at 12 lbs 7 oz. Examination showed his throat to be red with shotty cervical adenopathy. A CBC had a WBC of 12,700, HCT 32%, and platelet count of 210,000. The differential had 26% neutrophils, 1% bands, 59% lymphocytes, 9% eosinophils, and 5% atypical lymphocytes. He was placed on Acetaminophen and symptomatic measures. His weight was remeasured 3 days later and shown to be 12 lbs 6 oz. He demonstrated little interest in feeding. A repeat CBC had a WBC of 12,800, HCT was 30%, and platelet count was 175,000. The differential had 38% neutrophils, 2% bands, 46% lymphocytes, 5% monocytes, 2% eosinophils, and 4% atypical lymphocytes. The SMA 7 was normal. A sweat chloride was assayed with the result 30 (normal less than 55).

The child completely stopped feeding over the next 2 day period and was admitted to the hospital. Blood and urine cultures were collected and the child given lV fluids at a rate of 1500cc/m^2. After the third hospital day he began feeding better and was discharged home. The cultures were negative. His EBV profile was assayed and found positive for VCA lgG and EBV NA. His mother had positive titers for these antibodies, but at significantly lower levels. He was diagnosed with convalescing EBV illness and continues to do well at routine follow-up.

Discussion

Each child in this report had documented weight loss producing a transient growth failure.[6] This was the result of disinterest in feeding and inadequate calorie intake. Severe starvation and calorie deprivation in infancy may produce irreversible developmental deficits.[7] The children in this report have shown no developmental delay or additional growth problems.

The etiology in each case in this report, based on laboratory studies and physical examination, appears to be the Epstein-Barr virus. It is unclear from another report, but the Epstein-Barr virus may be a cause of anorexia, poor weight gain, and

weakness in children.[8] Other infections have been shown to interfere with normal growth. No family social problems were known to contribute to the growth failure of these children.

These children may have acquired EBV from either family or daycare contacts.[9] Cases 1 and 4 possibly acquired the virus from their mothers. These children had higher antibody titers than their mothers who were asymptomatic. The mothers may have been asymptomatic excreters of the Epstein-Barr virus. All the children had a short acute phase lasting several weeks. This may occur in young children.[10] Poor feeding may extend into the convalescent period.

Children who present with a disinterest in feeding accompanied by poor weight gain or weight loss, unremarkable history, a physical examination consistent with a viral infection and not seriously ill warrant screening for Epstein-Barr virus before receiving a full scale failure to thrive workup.

References

1. Shaheen E, Alexander D, Trùskowsky M, et al. Failure to thrive—a retrospective profile. *Clin Pediatrics.* 1968;7:255-261.
2. Tunnessen WW Jr. Anorexia. In: *Signs and Symptoms in Pediatrics.* Philadelphia, PA: JB Lippincott Co; 1983.
3. Green M. Anorexia. In: *Green and Richmond. Pediatric Diagnosis. Interpretation of Symptoms and Signs in Different Age Periods.* Philadelphia, PA: WB Saunders Co; 1980.
4. Simon MW. Correlation between clinical, physical and laboratory features in children with EBV illness. *J KY Med Assoc.* 1993;91:504-508.
5. Simon MW. Apnea associated with Epstein-Barr virus infection. *Ped Infect Dis J.* 1994;13:82.
6. Collins J, Mezey AP. Failure to Thrive. In: Shelov SP, Mezey AP, Edelmann CM Jr, Barnett HL, eds. *Primary Pediatric Care.A Symptomatic Approach.* Norwalk, CT: Appleton-Century-Crofts; 1984.
7. Hertzig ME, Birch HG, Richardson SA, et al. Intellectual levels of school children severely malnourished during the first two years of life. *Pediatrics.* 1972;49:814.
8. Sumaya CV, Ench Y. Epstein-Barr virus infectious mononucleosis in children. I. Clinical and general laboratory findings. *Pediatrics.* 1985;75:1003-1010.
9. Simon MW. Intrafamilial spread of Epstein-Barr virus. *J KY Med Assoc.* 1995;93:453-455.
10. Simon MW. Apnea of infancy associated with Epstein-Barr virus infection. *J KY Med Assoc.* 1993;91:401-402.

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Mobile Mammography Screening: The James Graham Brown Cancer Center Three Year Experience

Implications for Public and Professional Education

Michael B. Flynn, MD; Elizabeth A. Amin, MD; Robert C.G. Martin, II, MD

Objective: Review the mobile mammography screening experience at the James Graham Brown Cancer Center during a 3 year interval.
Methods: Collect and analyze demographic and outcome data on the screened population.
Results: 4,864 women underwent two-view mammograms. One third of the mammograms were performed in women over 50 years of age. 232 mammograms were carried out per cancer detected. The number of mammograms per cancer detected was 2.5 times higher and the number of biopsies per cancer detected was 2.8 times higher in women under 50 years of age. Two thirds of the cancers detected were in the over 50 age group which represents one third of the study population.
Conclusions: In this study, mammographic screening for breast cancer was more cost effective because a higher yield of cancers detected was obtained with fewer mammograms and fewer breast biopsies in women over 50 years of age, compared to women under 50 years. Resolving the question of the cost effectiveness of screening women aged 40 to 49, will require a large randomized prospective trial. In the near term, rather than to dwell on this issue, we would propose that this study suggests the need for greater emphasis in both public and professional education on breast cancer detection directed to women over 50 years of age.

The most controversial issue in the breast cancer screening debate involves breast cancer detection guidelines for women aged 40 to 49 years.[1-11] One side of this debate suggests that scientific data do not demonstrate a significant reduction in mortality from screening mammography in women under 50 years of age. The opposing view proposes that there is evidence that screening mammography for women younger than 50 will produce a modest reduction in mortality with the added advantage of the opportunity for more conservative therapy and is therefore justified. This study was carried out to review the experience of the James Graham Brown Cancer Center Mobile Breast Program in light of this controversy. The first mammograms performed were carried out at the Louisville Chamber of Commerce in April 1990. This study was initiated after operational start-up issues of this new program had been resolved and was conducted as part of an ongoing evaluation of the program. For the duration of the study, all mammograms were reviewed by the same radiologist (Dr Amin, a co-author), whose primary professional interest was the development and maintenance of the mammography program and who contributed a high level of expertise to this process.

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Materials and Methods

From August 1, 1990, to July 31, 1993, 4,864 women underwent two-view mammograms on the James Graham Brown Cancer Center mobile van. The reporting system used at that time contained four mammographic classifications: normal, probably benign, suspicious for cancer, and need more information.[12] Subjects for mammography originated from three sources; (1) screenings scheduled through the Kentucky State Health Departments as part of a state funded Cancer Control Program for medically indigent women, (2) women examined through corporate arrangements or sponsorships, and (3) women examined as a result of public availability of the mobile van. Mammography carried out through corporate arrangements included employees and/or relatives of employees of an assortment of business organizations in Kentucky. During public screenings, the mobile van was

Table 1. Criteria for Mammography

Age 35 or older*
Last mammogram 12 months ago or longer
No clinical complaints**
Name of a physician to do breast physical exam and to receive mammography report

*If a woman under the age of 35 made a special request for a baseline mammogram because of a family history of breast cancer, permission was given if she was 30 years or older;

**Mammography technologists were told not to turn away any woman who had a breast lump or any other complaint. These mammograms were not included in the screening group.

available at county fairs, the Kentucky State Fair, and other circumstances where mammography was provided on a walk-in basis.

Individuals requesting mammography were registered by the van personnel. A history was obtained and the mammogram was performed. The mammograms were processed and examined by the radiologist at a later date. Criteria for mammography used at that time are shown in Table 1. Evaluations did not include a breast physical examination. Observed frequency distributions are tested against the hypothesis of no relationship using the chi-square contingency test.

Table 2. Age Comparison

	Under 50 Years Old	Over 50 Years Old	Total
Mammograms	2,970	1,894	4,864
Additional Views	195	125	320
Breast Biopsies	55	35	90
Cancers Diagnosed	8	13	21
Ratio (Cancer/Mammograms)	1/371	1/145	1/232

Table 3. Mammographic Interpretation

	Mammograms	Additional Views	Biopsies	Cancer
Normal	4,192	86	4	1
Probably Benign	620	222	57	3
Suspicious for Cancer	32	8	26	17
Need More Information	20	4	3	0
TOTAL	4,864	320	90	21

Results

Comparison by age revealed almost two-thirds of the mammograms were performed in women under 50 years of age. No differences were noted in the proportion of additional views or biopsies relative to the total number of mammograms in the under 50 and over 50 age groups (Table 2). In women under 50 years of age, over twice as many breast biopsies were performed for each cancer diagnosed compared to women over 50 years.

The overall frequency of cancers detected to mammograms was 232 per cancer detected (Table 2). The ratio of mammograms performed per cancer detected was over 2.5 times higher in the under 50 age group ($P < 0.05$).

Mammographic Interpretation

Most of the diagnosed cancers were identified in the suspicious for cancer group (Table 3). The largest number of additional radiologic views and largest number of biopsies were in the probably benign category, resulting in identification of 14% (3/21) of the cancers; this group also had a low yield of cancers diagnosed. In comparison, a high yield of cancers diagnosed with relatively low utilization of additional views and a low biopsy to cancer ratio was found in the suspicious for cancer group. These observations were seen in both the under and over 50 age groups.

Breast Biopsies

Ninety biopsies were performed to identify 21 cancers for a ratio of 4.2 breast biopsies for each cancer diagnosed. In women over 50 years, 2.5 breast biopsies were performed to diagnose each cancer compared to 7 breast biopsies for each cancer in women under 50 years ($P < 0.05$).

Cancers Detected

Seventeen malignancies were diagnosed in 32 mammograms reported as suspicious for cancer for a 54% cancer detection rate compared to 0.4% cancer detection rate in the probably benign group and 0.002% in the normal category (Table 3). In this study, the overall sensitivity of the mammogram to detect cancer when it is present in this population of women is 0.81. The ability of the mammogram to correctly identify patients without disease (specificity) is 0.9969. Of the 15 mammograms categorized suspicious for cancer in women under 50 years of age, 7 cancers (46%) were detected compared to 10 cancers (58%)

detected in 17 mammograms read as suspicious for cancer in women over 50 years.

Demographics

Comparisons by demographic origin (health department, corporate or public screenings) did not reveal any clear differences (Table 4). The largest cohort were in the corporate group which utilized the lowest proportion of additional views compared to the public and health department groups. The highest number of mammograms per breast biopsy was seen in the public group. One cancer per three biopsies was found in the public group compared to one cancer per four biopsies in the corporate group, and one cancer per six biopsies in the health department group. The lowest number of biopsies per mammogram and the highest number of biopsies per cancer was seen in the health department group. The lowest number of mammograms per cancer were in the public group compared to the corporate and the health department groups which were roughly the same. The corporate group contained 2.5 times as many women under age 50. The public and health department groups were similar in that, the number of women under age 50 was only slightly higher than the number of women over age 50.

Table 4. Demographic Origin of Study Population

	Public Screenings	Corporote Screenings	Health Deportment Screenings
Mommograms	1,388	2,259	1,217
Additional Views	130	105	85
Breost Biopsies	21	40	29
Concers Diognosed	7	9	5
Under 50 Years Old	713	1,631	626
Over 50 Years Old	675	628	591
Cancer/Mommogrom Ratio	1/198	1/251	1/243

Discussion

Approximately one third of the mammograms were carried out in women over 50 years of age (Table 2). Roughly equal proportions of women over and under age 50 were found in public and health department screenings. The corporate-sponsored mammography group contained a much higher proportion of women under the age of 50. Women under 50 tend to participate in breast cancer screening programs in equal or greater proportions than women over 50.[1,2,13] The ratio of mammograms to cancers detected is roughly 2.5 times higher in the under 50 age group. The proportion of additional views and breast biopsies were roughly the same in both age groups. Two thirds (13/21) of the cancers were detected in the over 50 age group, representing one third of the total population examined. Ironically, this group of older women represents a smaller proportion of women examined in this and other studies. The number of mammograms per cancer detected was 2.5 times higher and the number of biopsies per cancer detected was 2.8 times higher in women under 50 years of age. This represents inherent difficulties in the radiologic interpretation of mammograms in younger women.[2]

Eighty percent of the cancers diagnosed were identified in the suspicious for cancer group. The largest number of additional radiologic studies were performed in the probably benign group, resulting in the highest number of breast biopsies and the identification of only 14% (3/21) of cancers. The precise identification of radiologic evidence of malignancy demonstrated in the high yield of the suspicious for cancer category is a direct manifestation of the value of a highly skilled and experienced mammographer. This further raises the question of the appropriateness of mammographic interpretation by general radiologists who are not exposed to a high volume of mammograms or have not received specific training.

Surgeons nationwide have expressed concern over the dramatic increase in the number of benign breast biopsies being performed as a result of screening detected mammographic abnormalities. For almost a decade, the American College of Radiology Breast Cancer Detection Committee worked with dedicated mammographers to develop a standardized terminology for describing mammographic abnormalities and standardized "work-up" recommendations for further evaluation of abnormalities; the latter should significantly reduce the number of benign biopsies thus increasing the yield of breast cancers.[14]

Stratification by demographic origin revealed that a large proportion of younger women under 50 years were found in the corporate-sponsored group. Parenthetically, this resulted in the lowest utilization of additional views compared to public and health department groups. No other notable findings were observed.

In a perfect world with unlimited resources, issues of cost effectiveness and efficiency are of minimal importance. Unfortunately, as the health

care system in the United States undergoes change, it is clear that the availability of resources to provide services will be increasingly limited in the future. Under these circumstances, issues of cost effectiveness and efficiency take on greater importance. In this study, the overall sensitivity of the mammograms is 0.81 and higher than reported in other studies.[15] We would ascribe this to the fact that our results occurred with an experienced radiologist dedicated to reviewing all mammograms, which resulted in a higher cancer detection rate in women over 50 years of age. This high level of professional expertise is an important consideration in operationally conducting mammographic screenings in the most cost-effective manner.

Mammographic screening for breast cancer in women over 50 years of age reduces mortality compared to women of the same age who have not undergone mammographic screening, and the reduction in mortality is higher than achieved by mammographic screening in women 40 to 49 years of age.[1] This study and other studies have suggested that mammographic screening in women over 50 is more cost-effective in that the number of mammograms per cancer detected and the biopsies per cancer detected are lower in women over 50 years of age compared to women under 50 years of age.

Resolving the question of the cost effectiveness of mammogram screening women aged 40 to 49 will require a large randomized prospective trial. Rather than dwell on this issue, we would propose that this study suggests the need for greater emphasis in both public and professional education on breast cancer detection directed to women over 50 years of age. Our experience is consistent with other surveys suggesting that older women tend to be less health conscious, more afraid of having a malignancy, less willing to encounter discomfort, embarrassment or inconvenience of mammography than younger women. Consequently, they tend to participate less in available screening activities than younger and better informed women unless encouraged either by a physician or specifically tailored programs.[13]

References

1. Eddy DM, Hasselblad V, McGivney W, Hendee W. The value of mammography screening in women under age 50 years. *JAMA.* 1988;259:1512-1519.
2. Kerlikowske K, Grady D, Barclay J, Sickles EA, Eaton A, Ernster V. Positive predictive value of screening mammography by age and family history of breast cancer. *JAMA.* 1993;270:2444-2450.
3. Volkers N. NCI replaces guidelines with statement of evidence. *J Natl Cancer Inst.* 1994;86:14-15.
4. Shapiro S, Serax P, Venet L. Evaluation of periodic breast cancer screening with mammography: Methodology and early observations. *JAMA.* 1966;195:731-738.
5. Shapiro S, Venet W, Serax P, Venet L. Periodic screening for breast cancer: The health insurance plan project and its sequelae, 1963-1986. Baltimore: Johns Hopkins University Press, 1986.
6. Miller AB, Baines CJ, To T, Wall C. Canadian national breast screening study: 1. Breast cancer detection and death rates among women aged 40 to 49 years. *Can Med Assoc J.* 1992;147:1459-1476.
7. Mettlin C, Smart CR. Breast cancer detection guidelines for women aged 40 to 49 years: Rationale for the American Cancer Society reaffirmation of recommendations. *Cancer.* 1994;44:248-255.
8. Eckhardt S, Badelinno F, Murphy GP. UICC meeting on breast-cancer screening in premenopausal women in developed countries. *Int J Cancer.* 1994;56:1-5.
9. Chu KC, Smart CR, Tarone RE. Analysis is breast cancer mortality and stage distribution by age for the health insurance plan clinical trial. *J Natl Cancer Inst.* 1988;80:1125-1132.
10. Feig SA. Follow-up studies of the health insurance plan study and the breast cancer detection demonstration project screening trials in the USA. *Recent Results Cancer Res.* 1990; 119:39-52.
11. Nystrom L, Rutquist LE, Wall S, et al. Breast cancer screening with mammography: overview of Swedish randomized trials. *Lancet.* 1993;341:973-978.
12. Kopans DB. Standardized mammography reporting. *Radiol Clin North Am.* 1992;30:257-261.
13. Rimer BK. Improving the use of cancer screening for older women. *Cancer.* 1993;72:1084-1087.
14. Kopans DB, D'Orsi CJ, Adler DD, et al. American College of Radiology Breast Imaging Reporting and Data System. Reston, Va: American College of Radiology; 1993.
15. Beam CA, Layde PM, Sullivan DC. Variability in the interpretation of screening mammograms by US radiologists. *Arch Intern Med.* 1996;156:209-213.

Webster's New Edition

There has been a plethora of things that I have learned once I was out in the "real world" of office and hospital practice. So many new concepts, in fact, that at one point I remember musing over the possibility of getting those three nice letters M.B.A. Or at the very least, I chastised myself for having not taken my father's advice and studying economics and finance in undergraduate school. Silly me . . . I packed my days with science and math courses so as to prepare myself better for the field of medicine.

Of course, there was also the time that I seriously contemplated law school, feeling that a J.D. might actually benefit me more. My husband quickly replied that I would probably be quite good at it. Was that a compliment?

In any event, I thought I would share some of the concepts that I have had the opportunity to learn. These words should all be added to the next addition edition of *Webster's Dictionary.*

Managed Care: Let's start with a good example of an oxymoron, or should we add the prefix "MIS"? Enough said.

Guest Relations: Obviously there is no need for doctors because we no longer have patients. We have guests, or clients, or customers. Did I get my degree in Hotel Management?

Right Sizing: Not "down" sizing anymore — the euphemism for deleting personnel (excuse me . . . FTEs . . .)

FTE: Full time equivalent — a.k.a. the people and staff that do the work, your co-workers.

Medical Information: This is another one that needs the prefix "MIS," for there is never the report you need in the record when you need it.

V.A.L.U.E. Matrix: Never have figured this out; this was a mnemonic we memorized prior to JCAHO inspection.

P.I.P.: Process improvement program. Another committee and more paperwork generated so we can show how we constantly strive for C.Q.I. . . . which brings us to . . .

C.Q.I.: Continuous quality improvement — why we have to have a process for something we all should be doing anyway, I'll never understand.

Clinical Path: Someone's way of dictating therapeutic options so the patients don't take up any more bed space.

Restrictive Covenant: Our own profession's thinly veiled internal way of denying "any willing provider."

Good Will: Actually, this is the contractual antithesis of "good."

Chairperson: This is what you call a woperson who is the head of a committee.

Any my personal favorite . . . . . .

Product Line: Used to refer to patients with certain diseases. I guess this is all a part of a good manufacturing practice.

Perhaps I'll do what I enjoy the most: Ignore all of these, and concentrate on the art and science of medicine.

You can cancel my order for the new *Webster's.*

Carolyn D. Burns, MD

It's Time To Tell Your Patients What They Need To Hear.

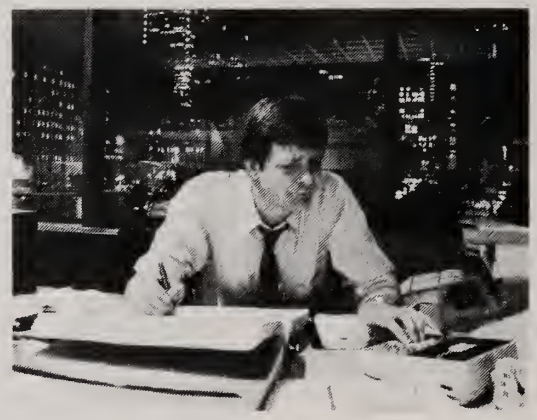


Lou's gradual hearing loss eventually became a detriment to the team.

The Louisville Hearing Aid Center's patient referral program provides an excellent opportunity to work together for the mutual benefit of those who come to us for care. It's quite simple; if any of your patients are experiencing hearing loss, refer them to us. In turn, we'll refer to you any of our patients that are in need of the specialized care that you provide. Everyone benefits. Especially the patients. For more information, give us a call at (502) 459-HEAR. Let's cover all the bases.

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American Heart Association

WE'RE FIGHTING FOR YOUR LIFE

Membership



Karen King

Below is a list . . . from a recent telephone conference. These are examples to be used in your county membership drive.

1. Please pay your dues — If you can't work with us, we'll work for you.
2. "An Alliance volunteer working for you" on buttons worn by Alliance members when doing community service.
3. If you can't be active, be informed.
4. Together Everyone Achieves More (TEAM).
5. Membership begins with me.
6. Every member get a member.
7. One person can make a difference.
8. "Take a membership moment" where members write a postcard to members that have not attended any recent meetings or events.

The ABCs of Membership: TIPS FOR RECRUITING YOUNG MOTHERS

A dopt a school and encourage use of AMAA programs in the school.
B aby sitting provided at meetings is a must for young Moms.
C ommunication is paramount. Ask for space in your newsletter to develop a personal column, ie, "FYI" depicting what is happening in member's families.
D evelop a series of lectures that will be fun and educational; ie, speakers from the local zoo and museums.
E ncourage members to attend a Confluence or other leadership training program.
F orm play groups.
G reeters at each meeting. 1) to welcome each and every member and 2) to assign someone to sit with each new guest at the meeting.
H ave fun and maintain a sense of humor.
I dentify young mother's specific needs and help create a program to address them.
J oin committees on the Alliance and bring fresh and creative ideas with you.
K ey to success — Members need to feel welcome and needed — assign simple jobs to new members.
L end a hand to someone who needs it — form support groups for specific problems.
M embership begins with me — Encourage a commitment for each member to get a member.
N o one asked syndrome — make sure you contact all prospective members and ask them to join.
O ne on One — Still the best way to reach prospective members and retain seasoned ones!
P lan a welcoming party for new members of both the society and alliance and invite the leaders for both groups to attend.
Q uestionnaire requesting information as to what the young mother members expect from the Alliance and asking what the members can do for the Alliance.
R etention — Keep members involved — ask young moms to do jobs from home, ie, phoning, researching, etc.
S unday afternoon events such as B-B-Que or Picnic involving the entire family. Use this time to introduce children's programs such as the three workbooks, and "Hands are not for Hitting."
T ail Gate parties before an event encourages participation from families.
U pdate your membership application.
V isit your community Battered Women and Children's Shelter and find out how you can help them.
W ork with other coalitions that involve children.
X -tra ordinary membership values: The ability to make a difference in matters that count: Friendship and leadership skills to mention a few.
Y ou can make a difference — one voice joined with many has the power to make a difference.
Z ero in on resident and medical student spouse groups in your area — provide a coffee or underwrite a luncheon and attend.

Karen King
Chair, Membership Committee



Aroona Dave

Many Members Making Membership A Major Matter Means Maximum Membership

Many thanks to Kentucky Medical Association and especially Diane Maxey who helped our Membership Committee to design and put a very informative updated Membership Brochure together. Approximately over 700 of them have been mailed to the prospective members in the organized counties. Organized counties' membership chairs are using them to recruit new members and retain old ones. Where one is Silver, the other is Gold.

It takes one to make a difference. Winnie Mitchell in Madison County is that one person. Winnie recruited energetic, proactive and willing members and there they are. They now have a County Medical Society Alliance that is organized.

Join me in congratulating them! Madison County Medical Society Alliance WELCOME TO OUR FAMILY!

Aroona Dave
KMAA President



Physician Impairment and Health: A Brief Overview

by Larry S. Goldman, MD

In 1972, the American Medical Association's (AMA) Council on Mental Health published its report,[1] "The Sick Physician," drawing the profession's and the public's attention to the problem of impaired physicians. The report noted that numerous articles had appeared in the medical literature during the preceding 15-20 years suggesting that substance abuse (including alcoholism), other mental disorders, and suicide were significant health problems among physicians. This AMA report called for (1) all physicians to take responsibility for impaired colleagues, (2) the referral of impaired colleagues to appropriate committees or boards in order to obtain treatment and to protect patients, (3) educational programs for medical trainees about these problems, and (4) the development and implementation of model legislation for states in dealing with impaired physicians.

Although "sick doctor statutes" were already on the books in Florida (1969) and Texas (1971), this report catalyzed a period of increased legislative and regulatory activity. It also led to the establishment of new programs to assess, treat, and/or monitor impaired physicians; new course offerings in medical schools and residencies to educate trainees and to attempt to "inoculate" them against this occupational hazard; and additional research to clarify the nature, risk factors, course, and outcomes for impaired physicians.

During this time (1970s and early 1980s) most of this activity was focused on alcoholism and other substance abuse, and the emphasis was on physician impairment and recovery from these substance use disorders after they had already taken their toll. Eventually every state had developed some program to deal with affected physicians, and as more physicians came (or were sent) forward into these programs, more clinical and epidemiologic information began to accumulate.

First, subsequent studies of addiction rates among trainees and practicing physicians suggested that overall, physicians' misuse of substances was not necessarily greater than that of nonphysicians of comparable age and other similar demographic factors.[2,3] While rates of abuse of prescription drugs seemed to run somewhat higher, rates of illicit drugs were quite a bit lower.[4] Secondly, there was a growing appreciation for the occurrence in physicians of other mental disorders, particularly depression and bipolar disorder. These conditions were seen both as co-occurrent with substance use disorders or simply by themselves. Finally, there were other conditions which caused impairment that were not mental disorders or at least which did not fit well into standard psychiatric nomenclature. In the first group were physical infirmities, including cardiac, musculoskeletal, neurologic (stroke, MS, blindness, etc), and other conditions.[5] The second category consisted of behavioral problems such as sexual exploitation of patients or abusiveness towards patients or co-workers.[6]

Many impaired physician programs were developed in conjunction with state medical societies. In some cases this was simply a small, voluntary committee of society members, but certain states began to develop more extensive programs with a professional staff and even medical directors. An ongoing tension has been the relationship between these programs and the state licensing boards.[7] The licensing boards, which are charged with a primary mission of public protection, have sought to know as much as possible about any cases of physician illness or impairment. Some states have created "diversion programs," which allow physicians to be referred to health programs without having to be reported to their state licensing boards. States with those arrangements have generally found that they are able to get more physicians to enter treatment voluntarily, often at earlier stages of their illnesses (ie, before they were so impaired they did something to warrant licensing board reporting or action).[8,9]

As these programs came to enjoy the trust of their licensing boards and of physicians, the scope of types of cases coming to the programs increased. This expanded clinical demand — along with the research findings mentioned earlier — has led the field to a shift from substance abuse and impairment to broader consideration of disorders of all types and incorporation of disease prevention and health promotion.

As the field of physician health has continued to evolve, there has been an ongoing need to disseminate new information about clinical practice, program development, and regulatory issues to practitioners, administrators, and educators. One forum for this dissemination has been a series of international conferences held every 1-2 years which are co-hosted by the

AMA and the Canadian Medical Association. These three-day meetings, alternating between US and Canadian venues, generally bring together 300-400 people, mostly from North America and Europe, with an interest in physician health. The most recent conference was held February 7-10, 1996, in Chandler, Arizona. The conference included half-day updates (institutes) on psychiatry, substance abuse, and women's health, as well as five plenary speakers who discussed topics as diverse as women in surgery, spirituality, medical students, the Americans with Disabilities Act, and population-based medicine. Presentations were held on stress in medical schools; managing medical and psychoactive drugs in recovering physicians; intervention strategies for physician health committees; monitoring physicians with personality disorders; fund-raising for physician health programs; national efforts to assist impaired physicians; and the effects of the "health care crisis" on physicians' emotional health, among others.

The next such conference will be held April 29-May 2, 1998, in Victoria, British Columbia, Canada. The theme, *Managing Our Own Care: Surviving the Health Care Revolution,* will emphasize the effects of the changing health care delivery system on physician well-being. The call for papers was open to a broad range of submissions, with a particular emphasis on: stresses related to changes in health care systems; primary prevention of illness and impairment; needs of particular physician populations such as trainees, older physicians, minorities, women, and IMGs; physical illness and disability; rehabilitation, re-training, and re-entry; the relationship between physician factors and medical errors; physician and family self-care and reactions to illness or stress; reactions to bad outcomes and lawsuits; harassment of and by physicians; relationships among hospital programs, state programs and licensing authorities; and dealing with physicians who misprescribe.

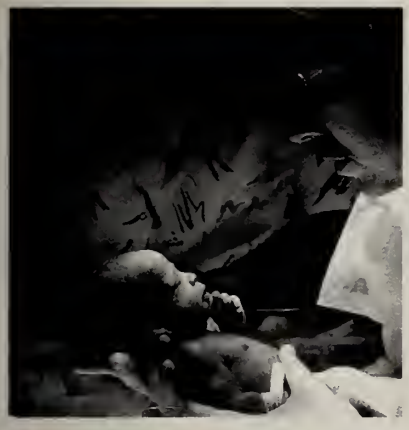
For additional information on the conference call the AMA Department of Mental Health at 312-464-5066. Information can also be found on the World Wide Web at **www.ama-assn.org** or at **www-psy.bsd.uchicago.edu/~larry/uchome.htm.**

References

1. Council on Mental Health. The sick physician: impairment by psychiatric disorders, including alcoholism and drug dependence. *JAMA* 1972; 223:684-687.
2. Brewster JM. Prevalence of alcohol and other drug problems among physicians. *JAMA* 1986; 255:1913.
3. Hughes PH, Brandenburg N, Baldwin DC. Prevalence of substance abuse among US physicians. *JAMA* 1992;267:2333-2339.
4. Council on Scientific Affairs. *Substance Abuse Among Physicians.* Chicago: American Medical Association; 1995.
5. Corbet B, Madorsky JG. Physicians with disabilities. *West J Med* 1991;154:514-521.
6. Summer GL, McCrory E. Professional sexual misconduct. Alabama Med *1994;64:4-6.*
7. Ad Hoc Committee on Physician Impairment. Report of the ad hoc committee on physician impairment. *Federation Bulletin* 1994;81:229-242.
8. Casper E, Dilts SL, Soter JJ et al. Establishment of the Colorado physician health program with a legislative initiative. *JAMA* 1988;260:671-673.
9. Ziegler PP. The physicians' health programs of the educational and scientific trust of the Pennsylvania Medical Society. *Federation Bulletin* 1995;82:151-154.

Dr Goldman is Director of the Department of Mental Health, American Medical Association, and Clinical Associate Professor, Department of Psychiatry, University of Chicago.

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Reference Committee G
(Medical Practice and Facilities)
AMA Interim Meeting, December 7-10, 1997

This article is written one week before the interim meeting of our American Medical Association House of Delegates, which will take place December 7-10, 1997, at Dallas, Texas. Reference Committee G typically deals with issues involving medical practice and facilities.

One of the main points of discussion and controversy for Reference Committee G this year will be the "Sunbeam" issue. There presently are eight resolutions and probably more to come which deals with the issue calling for various actions. I will try to summarize what has taken place to this point.

Earlier this year, representatives from the AMA and Sunbeam began exploring the idea of establishing a partnership to provide consumers with health information. This information would be with Sunbeam Corporation's line of "Health at Home" products, which include vaporizers, blood pressure monitors, heating pads, hot and cold packs, and air and water filters.

Our AMA seal or logo would appear on the packaging along with a notice informing the consumer that valuable medical information could be found inside. It apparently was felt that our AMA would benefit because Sunbeam would pay us a royalty on sales thereby helping our AMA support its many educational programs. Consumers would benefit by getting balanced health care information. Sunbeam would benefit by having the AMA logo standing behind its products. Throughout the spring and summer of this year, Sunbeam and AMA personnel negotiated the terms of the agreement. This was signed apparently by the AMA's chief operating officer on the 5th of August, 1997. A press conference announced the contractual agreement one week later. Almost immediately, our AMA came under serious criticism from the membership, the media, and the public. There was great concern that this type of activity involving the AMA is unethical, involves conflict of interest, and is improper. The AMA Board of Trustees initially tried to institute "Damage Control" and stated that they were not aware of the details of the contractual agreement or a part of the negotiations. After a subsequent meeting of the Board, the AMA informed Sunbeam that it was withdrawing from the contract. Sunbeam subsequently filed a $20 million lawsuit against the AMA.

Sunbeam Corporation has stated that it is not about to surrender fundamental aspects of the program. They feel they have every right to hold the AMA to the negotiated agreement and will continue to pursue its contractual rights.

Percy Wooten, MD, President of the AMA, spoke to the Kentucky Medical Association House of Delegates at its September annual meeting. He made it a point to distance the AMA Board of Trustees from the knowledge of the negotiation and the actual signing of the agreement. He vowed that the failure of the usual safeguards in place at the AMA to prevent this type of situation would be thoroughly investigated.

The Board of Trustees of the AMA has taken a series of actions including extensive review of the events which transpired, the apparent circumvention of applicable AMA policies and procedures, and the resignation of some high level AMA staff.

The AMA House of Delegates, however, is the body ultimately responsible for AMA policy. Constituent chapters and members of the House are still quite concerned. Several of the resolutions are calling for a committee to be formed by the House of Delegates and not by the Board of Trustees to investigate the Sunbeam issue and related issues of non dues income and related contracts, also to study policy and procedural safeguards and report back to the House of Delegates in June.

The ultimate goal is to prevent a recurrence of this embarrassing situation. The credibility of our AMA as the ethical voice of medicine must be maintained.

Donald J. Swikert, MD
AMA Delegate

Committee on Medicaid Managed Care

by Donald R. Neel, MD

The way the Medicaid system is run in Kentucky is changing. Despite the success of the nationally recognized KENPAC program, the state has decided to move Kentucky's Medicaid system into a new managed care program. Many other states have tried various Medicaid managed care initiatives, which have met with mixed results.[1] Kentucky, however, has initiated a unique project that is unlike any other system in the country. The state is essentially turning the Medicaid program over to Kentucky's medical providers. To do this, the Medicaid population has been divided into eight geographic regions, with each region having to form its own infrastructure and program, called "Partnerships," to service the Medicaid recipients. The state will pay each region a per member-per month fee to fund the operation of each Partnership.

While turning the program over to providers sounds tempting, the concept has encountered many pitfalls. For a Partnership to operate, providers in a given region must come together to form and operate the program. This is a daunting prospect, although many regions have worked very hard to bring the providers together. Each region must also establish an infrastructure to manage the system and the cost is astronomical. It has been estimated that $5 to $10 million is needed to fund such a project, which makes it very difficult for rural providers to fund the program. The regulations governing the Partnerships are, of course, intricate and complicated, which also makes forming one difficult.[2] Finally, many providers, not to mention patients, must be educated on the aspects and requirements of managed care, which is no small order.

While these problems do exist, two regions have already developed the necessary infrastructure to manage their Medicaid populations. Regions three and five, which encompass the Louisville and Lexington areas respectively, are in the process of enrolling patients into their programs. These regions have been supported by a strong urban base of providers, as well as the Universities, which have partially funded the programs. Both regions have overcome numerous roadblocks during development which will, hopefully, make it easier for other regions to avoid such problems. Regions three and five, of course, have the urban base which may be necessary to get the programs started. The rest of the state is not so lucky. The providers and patients in rural areas have little experience with managed care. The funding will also be a problem for these areas, although some of them are working hard to see that the potential for such a project is at least explored.

The state has said that if a region does not form a Partnership, the Medicaid system in that region will be put "up for bid" to private industry. This may be worrisome to many, although it has been apparent in the last few years that many private companies are not renewing their Medicaid managed care contracts in other states because they have been unable to turn a profit.[3]

While the Kentucky Medical Association has expressed many concerns about this project (not the least of which has been the contention that KENPAC is working) KMA wants to ensure its membership is properly apprised of developments in this program. To do this, KMA has created a new committee known as the "Committee on Medicaid Managed Care." This committee is comprised of two physicians from each of the eight Medicaid regions around the state and most of them have intimate knowledge of what is happening in their regions. We hope the committee will be a forum for these physicians to inform each other on what is going on and, possibly, exchange information to help physicians in all areas of the state better understand this new system. We intend to hold meetings throughout the year and pass on to the membership what we learn.

This is a challenging time in our profession with changes occurring almost daily. Kentucky's Medicaid system is just one example of these changes and KMA is working to keep the membership informed on the various aspects of this new system.

References

1. United States General Accounting Office. *Medicaid: Spending Pressures Drive States Toward Program Reinvention.* April 1995;6-7, 37-40.
2. 907 KAR 1:705.
3. Page L. HMOs back away from Medicaid. *American Medical News.* Jan 13, 1997; 3, 22.

Don Neel, MD, is a pediatrician in Owensboro, Kentucky. He is also the Vice-Chair of the KMA Board of Trustees and Chair of the new Committee on Medicaid Managed Care.

PEOPLE

Robert R. Goodin, MD, a Louisville cardiologist and past KMA President, has been reappointed to serve a one-year term (January 1, 1988–December 31, 1998) on the AMA Accreditation Council for Continuing Medical Education. Dr Goodin was appointed to serve as the AMA Executive Committee member.

David H. Neustadt, MD, a Louisville rheumatologist, received the American College of Rheumatology "Distinguished Rheumatologist Award" for 1997. The award recognizes a single ACR member for outstanding contributions in the areas of patient care, clinical scholarship, or service to benefit patients with rheumatic diseases. Dr Neustadt's career has spanned 43 years in Louisville. He is currently Clinical Professor of Medicine at the University of Louisville, and was formerly Chief and Director of the Division of Rheumatic Diseases at the University. He established the first rheumatology training program at the University of Louisville and continues to teach medical residents and fellows at the School of Medicine.

Barbara Phillips, MD, Lexington, is serving a 3-year term as president of the American Board of Sleep Medicine (ABSM). The American Board of Sleep Medicine was formed to produce an examination for the purpose of establishing and maintaining standards of individual proficiency in the field of sleep disorders medicine. According to ABSM, Dr Phillips plays an integral role in making sure all aspects of the examination process (Finance, Credentialing, Part I, Part II Committees) are functioning as they should.

Praised for his humanitarianism, University of Louisville anesthesiologist **Benjamin M. Rigor, MD,** was the winner of the U of L President's Distinguished Service Award, which was presented during the University's Celebration of Excellence ceremony. Since being named chair of anesthesiology in 1981, Dr Rigor has co-founded several voluntary medical missions including Operation Rainbow, Operation SMILE International, P.A.G.E.S. and Operation HOPE. Doctors and other medical personnel in these philanthropic organizations perform reconstructive surgery on impoverished patients in the Philippines and other developing nations in Asia, as well as provide a variety of other vital medical services, including medical training programs. Dr Rigor organizes the teams, which comprise surgeons, anesthesiologists and nurses.

UPDATES

U of L, Cancer Center Launch Follow-up Breast Cancer Study

More than 10,000 women who participated in a breast cancer study in the early 1970s at the James Graham Brown Cancer Center are being contacted to participate in a follow-up study about their general health, breast health, menstrual and hormonal replacement histories, and lifestyle.

The study builds on an extensive database of information gathered from 10,128 women who entered the Breast Cancer Detection and Demonstration Project (BCDDP) between 1973 and 1975. The cases of most women in the study were followed for a varying number of years afterward, but none have been contacted for at least 12 years.

The original study was funded by the National Cancer Institute and the American Cancer Society. The University of Louisville and the Brown Cancer Center participated as one of 29 sites nationwide. Statistical data generated from the trial contributed a great deal to the understanding and treatment of breast cancer, according to **John Spratt, MD,** professor of surgery and health systems and coordinator of the new study.

Dr Spratt participated as an examining physician in the original project. After coming to U of L in 1976, he authored or co-authored nearly 20 studies using BCDDP data. Those studies dealt with topics including cancer growth rates, risk factors, and tumor size detection thresholds.

Women who agree to be part of the follow-up study will receive forms indicating their willingness to participate along with the first of several surveys they will be asked to complete over the next few months.

Any woman who participated in the BCDDP project who would like to participate in the follow-up study should contact the BCDDP Follow-up Project, James Graham Brown Cancer Center, 529 S Jackson Street, Louisville, KY 40202. Inquiries should include the respondent's name as it appeared on the original 1973-75 entry data as well as a current name and address.

The current study is being funded by grants from the Louisville Regional Cancer Center Corp and the Adult Cancer Program at Alliant Health System.

For more information, call Dr Spratt at 502.852.5592.

U of L Faculty Promotions

KMA member physicians included in a list of faculty promotions at the University of Louisville are **Michael Heit,** obstetrics and gynecology, assistant professor; **Edwin Render,** anesthesiology, assistant professor; **Richard Blondell,** family and community medicine, professor; **Sheldon Bond,** surgery (pediatric), associate professor; **David Doering,**

obstetrics and gynecology, associate professor; **Sophia Franco,** pediatrics, professor; **Terence Hadley,** medicine (medical oncology/hematology), professor; **Stephen McClave,** medicine (gastroenterology), professor; **George Rodgers,** pediatrics, professor, and pharmacology and toxicology, professor; and **Wayne Tuckson,** surgery (general), associate professor.

Tactical Physicians Go on Site with SWAT Teams

University of Louisville emergency medicine residents now can opt for additional training as "tactical physicians" who accompany strategic weapons and tactics (SWAT) teams to crisis sites. The physicians treat anyone injured at the scene and can work with commanders before raids to evaluate potential problems — such as hazardous chemicals present in most illegal drug labs.

SWAT team members work with more confidence, says emergency medicine professor **William S. Smock, MD,** knowing that they'll receive immediate treatment in case of emergency. In return, physicians get excellent protection from the team.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

James B Carrico MD — R
4929 Robin Hood Dr, Ashland 41101-6835
1991, U of Louisville

Seth Dashe MD — OBG
118 St Christopher Dr, Ashland 41101-7016
1979, Northwestern U, Chicago

Kurt F Jaenicke MD — OBG
2001 Winchester Ave, Ashland 41101
1988, U of S Carolina, Columbia

Roderick J Tompkins MD — S
2222 Winchester Ave, Ashland 41105-1865
1992, U of Louisville

Calloway

Christopher Lee Poor MD — EM
5317 Dunbar Rd, New Concord 42076
1994, U of Illinois, Chicago

Daviess

Karen M Bickett MD — R
PO Box 807, Owensboro 42301
1991, U of Louisville

Roger L Humphrey MD — S
2816 Veach Rd Bldg 5, Owensboro 42303
1977, U of Texas, Southwestern

John D Lauzon MD — PD
2211 Mayfair Dr Ste 106, Owensboro 42301
1982, U of Kentucky

Arup Maitra MD — IM
2301 N Wintergreen Loop, Owensboro 42301
1982, Armed Forces Med Col, India

Fayette

Philip C Booker MD — AN
4030 Tates Creek Rd Apt 3956, Lexington 40517-3060
1992, U of Louisville

Jean E Cibula MD — N
UKMC Ky Clinic L445, Lexington 40536
1991, Case Western Reserve U

Richard Coleman MD — R
2213 Azalea Dr, Lexington 40504
1992, U of Tennessee

Robert W Lightfoot Jr MD — RHU
107 Woodside Way, Nicholasville 40356
1961, Vanderbilt

Jose M Manaligod MD — OTO
2485 Brookshire Cir, Lexington 40515-1228
1990, Illinois Med Col

Robert M Mentzer Jr MD — TS
UKMC Surgery, Lexington 40536
1971, Bowdoin, Maine

Khalil U Rahman MD — NEP
1517 Nicholasville Rd Ste 405, Lexington 40503
1984, Fatima Jinnah Col, Pakistan

Earl G Robbins II MD — GE
316 Colony Blvd, Lexington 40502
1990, U of Kentucky

David W Rudy MD — IM
104 Thoroughbred Ln, Nicholasville 40356
1983, Commonwealth U, Virginia

Grant

Joseph E Hartig MD — PD
PO Box 150, Dry Ridge 41035
1992, U of Kentucky

Hardin

Leigh A.Pearman MD — PD
1010 Woodland Dr, Elizabethtown 42701
1994, U of Louisville

Jefferson

Heath E Brown MD — OBG
9914 Arterburn Woods Dr, Louisville 40223-2800
1993, U of Louisville

Mohammad E Majd MD — ORS
416 Eline Ave, Louisville 40207-2940
1979, Faculty of Med Isfahan U, Iran

Mary L McCormick MD — IM
5511 Apache Rd, Louisville 40207
1980, U of Louisville

Richard N Medley III MD — S
9108 Linn Station Rd, Louisville 40222
1992, U of Kentucky

Johnson

Milot Frederick Faria MD — S
1110 S Mayo Trl Ste 5, Paintsville 41240
1986, Topiwala National Med Col, India

Madison

Gina L Land MD — OBG
311A Radio Park, Richmond 40475
1993, U of Kentucky

McCracken

Rajgopal R Pakanati MD — AN
2831 Lone Oak Rd, Paducah 42003
1988, Osmania Med Col, India

Pulaski

Owen S Maat MD — GE
118 Tradepark Dr, Somerset 42503
1992, U of Texas, Galveston

IN-TRAINING

Fayette

Hanna Mawad MD — NEP

Jefferson

Christopher R Grieves MD — EM
Girolamo Jerry Trotti MD — R

DEATHS

Robert L. McKenney, MD
Falmouth
1925-1997

Robert L. McKenney, MD, a general practitioner, died August 29, 1997. Dr McKenney graduated from the University of Louisville School of Medicine in 1954 and was an active member of KMA.

Harold B. Graves, MD
Harlingen, TX
1911-1997

Harold B. Graves, MD, a retired OB-GYN, died October 6, 1997. A 1937 graduate of Homeopathic Medical College of Missouri, Dr Graves was a life member of KMA.

Robert J. McCabe, MD
Newport
1921-1996

Robert J. McCabe, MD, a dermatologist, died October 12, 1997. Dr McCabe was a 1944 graduate of the University of Cincinnati College of Medicine, and an active member of KMA.

Mario W. Cartaya, MD
Campbellsville
1914-1997

Mario W. Cartaya, MD, a retired general practitioner, died October 12, 1997. A 1947 graduate of the University of Havana School of Medicine, Dr Cartaya was a life member of KMA.

David P. Edmundson, MD
Mount Sterling
1912-1997

David P. Edmundson, MD, a retired general practitioner, died August 31, 1997. Dr Edmundson was a 1936 graduate of the University of Tennessee College of Medicine and a life member of KMA.

Robert C. Smith, MD
Newport
1919-1997

Robert C. Smith, MD, a retired psychiatrist, died September 5, 1997. A 1945 graduate of the University of Cincinnati College of Medicine, Dr Smith was a life member of KMA.

Daniel H. Boeh, MD
Ft. Thomas
1910-1997

Daniel H. Boeh, MD, a retired general practitioner, died November 13, 1997. Dr Boeh was a 1936 graduate of the University of Cincinnati College of Medicine and a life member of KMA.

Thomas F. Whayne, Sr, MD
Lexington
1905-1997

Thomas F. Whayne, Sr, MD, a retired preventive medicine physician and former University of Kentucky assistant vice president and associate dean for administration and professor of community medicine died November 18, 1997. A 1931 graduate of Washington University School of Medicine, Dr Whayne was a life member of KMA.

CHS Nursing Home Review

The Cabinet for Health Services is instituting several changes in the way nursing care reviews are being handled for the Medicaid program that involve physicians.

Secretary John Morse has told legislators he wants to improve the appeals process and the communication between the cabinet, nursing home residents, their families, their physicians and HealthCare Review Corp, the peer review organization.

The changes include:

- HealthCare Review will not decertify anyone without first speaking to the attending physician. Attending physicians will be asked to fax a document to HealthCare Review to show why nursing care is not necessary.
- No decertification will occur without the patient's guardian being contacted by a representative of Medicaid to explain the process and appeal rights.
- A notice will be sent to the nursing home patient, the family, the doctor, the nursing home and the long term care ombudsman to explain their case is under review and that Medicaid criteria may not be met. This will help insure that HealthCare Review has access to the full medical record and speaks to the attending physician. This will occur before any decision is made to decertify a patient.
- The cabinet, with the help of the nursing home industry, will prepare a brochure to help educate patients and families about Medicaid coverage for long term care.

Morse said he wants to make sure the reviews are accurate and that HealthCare Review is making decisions based on the complete medical record.

The changes are in response to concerns about some nursing home patients receiving notices informing them they would lose Medicaid coverage. In some instances, HealthCare Review did not have access to complete medical records or had not spoken to the attending physician.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates: $40 per insertion ($20 for KMA members) for the first 30 words; 50¢ for each additional word.

Send advance payment with order to: The Journal of KMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222.

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CHANGING ADDRESS?

Please notify us at least two months in advance.

Send new address to:

Journal of the Kentucky Medical Association
The KMA Building
4965 US Hwy 42, Suite 2000
Louisville, KY 40222-6301

502.426.6200; Fax 502.426.6877

While you're looking out for your patients, who's looking out for you?

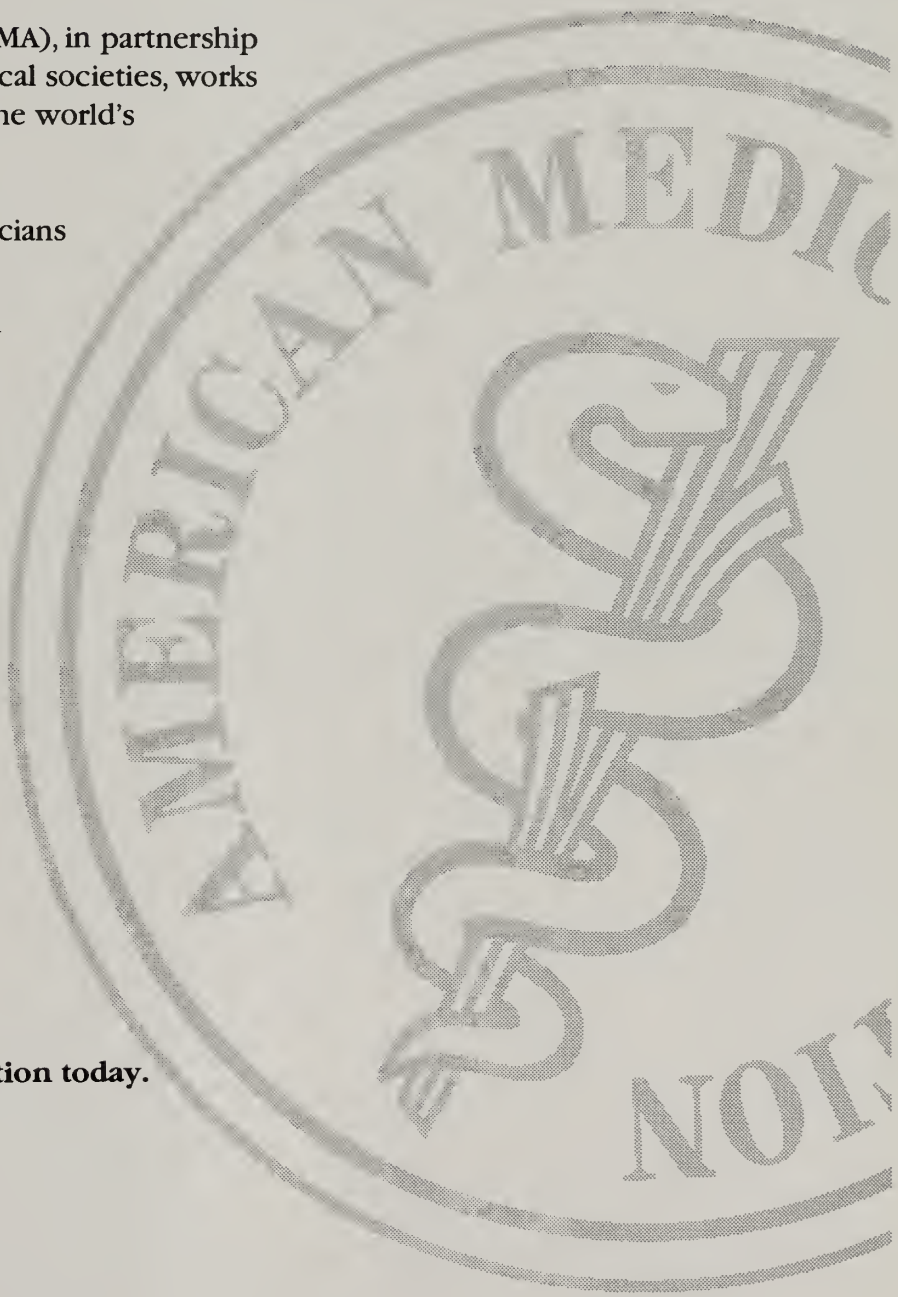
The American Medical Association (AMA), in partnership with state, county, and specialty medical societies, works to assure America's patients receive the world's highest level of quality care.

- Speaking out for patients and physicians with a single, powerful voice.
- Continuously advancing the art and science of medicine.
- Constantly promoting the highest ethical, educational, and clinical standards.

As a member of the AMA, you can add strength and credibility to our ongoing efforts to confront today's most critical health care issues.

Alone, you can touch a community. Together, we can change a nation. Join or renew your membership. Contact your state or county medical society today.

Give Power to Your Voice.
Join the American Medical Association today.



American Medical Association
Physicians dedicated to the health of America

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Useful Telephone Numbers

AMPAC	202-789-7434
KEMPAC	502-426-6200
Associations	
American Medical Association	312-464-5000 or 800-262-3211
American Medical Association Alliance	312-464-4470
Kentucky Academy Family Practice	502-451-0370
Kentucky Association Health Care Facilities	502-425-5000
Kentucky Bar Association	502-564-3795
Kentucky Dental Association	502-459-5373
Kentucky Hospital Association	502-426-6220
Kentucky Medical Association	502-426-6200
Kentucky Medical Association Alliance	502-426-6200
Kentucky Nurses Association	502-637-2546
Kentucky Pharmacy Association	502-227-2303
Kentucky Primary Care Association	502-227-4379
Kentucky Chamber of Commerce	502-695-4700
Kentucky Medical Insurance Agency	502-339-5750
Kentucky Medical Insurance Company	502-339-5700
Kentucky Physician's Care	800-633-8100
Kentucky Rural Medical Scholarship Fund	502-426-6200
Medical Societies	
Daviess County Medical Society	502-688-3165
Fayette County Medical Society	606-278-0569
Jefferson County Medical Society	502-589-2001
Northern Kentucky Medical Society	606-578-6802
Medical School Deans	
University of Kentucky	606-323-5567
University of Louisville	502-852-5184
Medicare	502-425-7776
Social Security Administration	800-772-1213
State Government	
Attorney General	502-564-7600
Department of Insurance	502-564-3630
Governor's Office	502-564-2611
Kentucky Board of Pharmacy	502-564-2032
Kentucky Board of Medical Licensure	502-429-8046
Kentucky Revenue Cabinet	502-564-6823
Kentucky Election/Finance Commission	502-573-2226
Legislative Research Commission	502-564-8100
Lt. Governor's Office	502-564-2611
Medicaid Department	502-564-4321
Secretary Cabinet for Health Services	502-564-7130

Foreword

The 1998 Kentucky General Assembly convened on January 6. The KMA Legislative Quick Action Committee will meet in Frankfort on a weekly basis to establish positions on various legislative proposals and direct the overall effort.

However, the major lobbying effort rests with the KMA Key Contacts and physician constituents of the members of the Kentucky General Assembly. The most important contribution you can make is to write a personal letter to your legislator outlining your personal concerns, particularly as they relate to your patients. Follow up that letter with a phone call. Then urge your fellow physicians to do the same.

If you have questions during the Session, don't hesitate to contact your Trustee, KMA officers, or staff. We are interested in your views and need your full support during these difficult times.



Wally O. Montgomery, MD

The Kentucky Medical Association gratefully acknowledges the Legislative Research Commission for its cooperation in providing photographs and much of the information in this publication.

You May Contact Your Legislator By Phone

When the General Assembly is in session, you may call your legislators in Frankfort at the following numbers:

Legislative Message Line **1-800-372-7181**
Bill Status Line **1-800-776-9158**
Meeting Information Line **1-800-633-9650**
Citizen Contact Line **1-800-592-4399**
Legislative Offices **502-564-8100**

KMA Officials

If you have questions during the session, don't hesitate to contact your Trustee, KMA Officers, or staff. The following numbers may be used:

KMA Headquarters **502-426-6200**
William T. Applegate (Executive Vice President)
Robert E. Klinglesmith (Director, Profession Relations)
Patrick T. Padgett (Director, Socioeconomic Affairs & Staff Counsel)
Diane M. Maxey (Director, Member Services)
Wally Montgomery, MD **502-441-4300**
(Chair, Committee on State Legislative Activities)
C. Kenneth Peters, MD **502-267-5456**
(KMA President)
J. Gregory Cooper, MD **606-234-6000**
(Chair, KMA Board of Trustees)

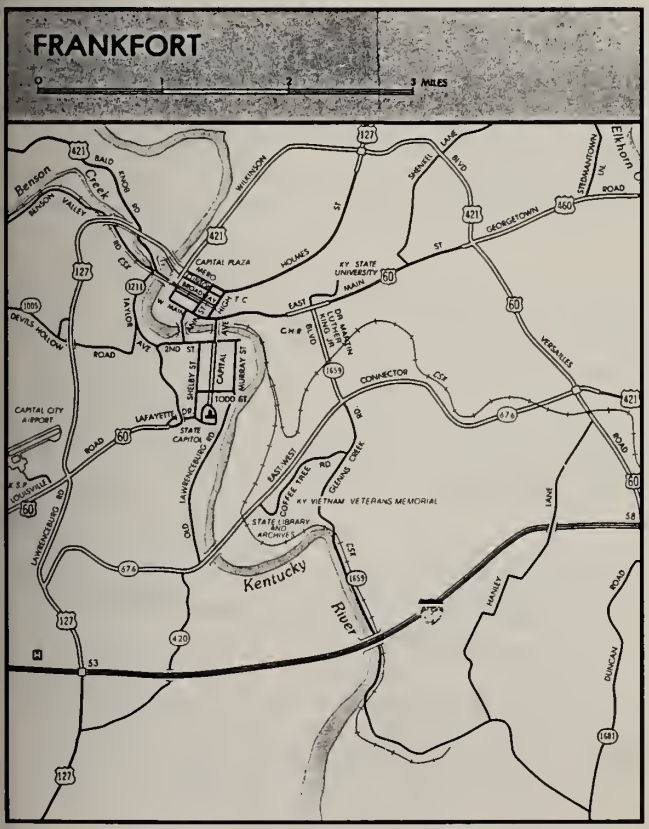
KMA Lobbyists (home phone numbers)

Don R. Chasteen, Louisville 502-429-5126
John P. Cooper, Georgetown 502-868-9128
William E. Doll, Jr, Frankfort 502-223-3150

"Every person owes part of his time and money to the business or industry in which he is engaged. No person has a moral right to withhold support from an organization that is striving to improve conditions within his sphere."
— TEDDY ROOSEVELT

Coming to Frankfort?

1. Contact your legislator and schedule a visit.
2. Contact KMA and arrange for a briefing by a KMA lobbyist prior to your legislative visit.
3. If your legislator is on a health-related committee, visit on a day the committee meets. You'll get a real perspective of their activities.
4. Time your visit — visit early and discuss important issues prior to a vote.
5. Keep up during the Session — drop a note thanking your legislators — reminding them of your position.
6. After the Session — remember their record on election day.



Duties of Officials

What are the duties of state legislators? Here are job descriptions for state senators and representatives:

There are 38 senators, each represent about 100,000 people and serve four-year terms; half the Senate is elected every two years. Each of the 100 representatives represent an average of about 38,000 people and serve two-year terms. The Senate and House of Representatives, which together are called the General Assembly, have a 60-day regular session in even-numbered years and a short organizational session in odd-numbered years, and can be called into special session by the Governor. Senators and representatives propose, consider, and vote on legislation dealing with topics such as the budget, education, health care, crime, the environment, and abortion. They vote whether to put constitutional amendments on the ballot and can review regulations issued by state agencies and state contracts.

Writing Effective Letters to Legislators

In communicating your ideas and positions on issues with legislators, writing a letter is the most effective. The following tips may help in presenting your views.

1. Use personal stationery.
2. Indicate which bill or issue you are addressing.
3. Get to the point! Do you support or oppose the bill.
4. Provide concrete, credible information on the legislation's impact.
5. Act promptly. Good letters arriving after a vote are useless.
6. Keep letters short. One-page letters have more impact than long ones.
7. If legislators do what you ask, send a thank you letter.

Letters can be mailed to the following address:

The Honorable (legislator's name)
Kentucky State Senate **OR**
Kentucky House of Representatives
Frankfort, KY 40601

Eight Major Mistakes in Dealing With Legislators

1. **Assume each legislator is a walking encyclopedia on every pending issue.**

   During a normal session of the General Assembly, approximately 1500 different bills are introduced with about one third becoming law. That's a lot of legislation to read, review and remember. It's virtually impossible for every legislator to know every bill, chapter and verse. Individual legislators are most familiar with three types of bills — those they personally sponsor, those that come before committees on which they serve, and those that someone in their district has urged them to either support or oppose.

2. **Expect a commitment on the spot.**

   Most legislators are thoughtful, deliberate types, who make a point to seek out all sides of a particular issue before taking a position. Remember that a good politician generally checks out the water's depth before diving.

3. **Come armed without the facts.**

   Smoke and mirrors won't do the job in winning a legislator over. You must demonstrate through tangible evidence supported by facts that a particular action is both desirable and justifiable — and the ultimate burden of proof is on you.

4. **Forget there's always another side to the issue.**

   Each state representative has an average of 37,280 constituents; each state senator has an average of 98,105. You can be sure that there's at least one constituent, if not more, who has a different position on an issue and, just like you, expects to have his or her voice heard. As one veteran officeholder is fond of saying, "Some of my friends are for this bill, some are against — and I'm sticking with my friends!"

5. **Run down the opposition.**

   Name-calling or derogatory remarks don't win friends and influence legislation. If your issue can't stand on its own merit, then your cause is already lost. Besides, your legislator's brother-in-law might be a key member of the group that's on the other side of the fence!

6. **Burn your bridges when you don't win.**

   Working with the legislators is an investment that may not pay off immediately. Don't burn your bridges if results aren't immediately forthcoming.

7. **Fail to say thank you.**

   Even though meeting with constituents comes with the territory for legislators, it's still an act that should be acknowledged. A thank-you note for taking the time to meet with you is always in order.

8. **Leave never to be heard from again.**

   One phone call or visit isn't enough. That means keeping in touch to let the legislator know that your interest is not a passing fancy. Stay on top of developments relating to your issue so that when new and relevant information becomes available, you can pass it along.

There's a doctor in the House . . . and Senate . . . and Executive Branch



Lt Governor Steve Henry, MD



Senator Nick Kafoglis, MD



Representative Bob M. DeWeese, MD

KENTUCKY'S SENATE DISTRICTS

Senate Leadership

ELECTIVE OFFICERS

President	Larry Saunders
President Pro Tem	Walter Blevins, Jr

PARTY LEADERS

Democrats

Floor Leader	David K. Karem
Caucus Chairman	Nick Kafoglis
Whip	Fred Bradley

Republicans

Floor Leader	Dan Kelly
Caucus Chairman	Dick Roeding
Whip	Elizabeth Tori



Senators by District

1 Robert L Jackson
2 Robert J "Bob" Leeper
3 Joey Pendleton
4 Paul Herron, Jr
5 Virgil Moore
6 Kim L Nelson
7 Lindy Casebier
8 David E Boswell
9 Richard A Sanders
10 Elizabeth Tori
11 Richard L Roeding
12 Timothy N Philpot
13 Ernesto Scorsone
14 Dan Kelly
15 Vernie McGaha
16 David L Williams
17 Glenn Freeman
18 Charlie Borders
19 Tim Shaughnessy
20 Fred Bradley
21 Albert L Robinson
22 Tom Buford
23 John D "Jack" Westwood
24 Gex "Jay" Williams, III
25 Robert Stivers
26 Ernie Harris
27 Walter Blevins, Jr, DMD
28 John A "Eck" Rose
29 Benny Ray Bailey
30 Denny Nunnelley
31 Gary C Johnson
32 Nick Kafoglis, MD
33 Gerald A Neal
34 Barry Metcalf
35 David K Karem
36 Julie Rose
37 Larry Saunders
38 Dan "Malano" Seum

Committee Roster 1998 Kentucky General Assembly

Committees of the Senate

Appropriations & Revenue

Bailey — Chair
Borders — Vice Chair
Casebier
Freeman
Johnson
Moore
Nunnelley
Pendleton
E. Rose
Sanders
Saunders
D. Williams
G. Williams

Banking & Insurance

Borders
Bradley
Buford — Vice Chair
Casebier
Robinson
Roeding
Scorsone
Seum — Chair
Shaughnessy
Tori

Economic Development & Labor

Blevins
Boswell
Freeman — Chair
Leeper
Moore
Saunders — Vice Chair
Shaughnessy
Stivers
D. Williams
G. Williams

Health & Welfare

Blevins
Buford
Herron
Neal — Chair
Pendleton
Philpot
Roeding
E. Rose
J. Rose — Vice Chair
Seum
Westwood

Judiciary

Johnson
Kafoglis
Karem
Neal
Philpot — Vice Chair
J. Rose
Saunders
Scorsone — Chair
Tori
Westwood
D. Williams

Licensing & Occupations

Boswell — Chair
Bradley
Buford
Kafoglis
Kelly
Metcalf — Vice Chair
Nelson
Nunnelley
Philpot
Roeding
Seum

State & Local Government

Bailey
Freeman
Harris
Herron — Chair
Johnson
Karem
McGaha
Robinson
J. Rose
Stivers
Tori

Transportation

Blevins
Boswell
Kelly
Leeper
Metcalf
Moore — Vice Chair
Nelson — Chair
Nunnelley
Robinson
E. Rose
Sanders

Rules

Blevins
Bradley
Kafoglis
Karem — Chair
Kelly
Roeding
Saunders — Vice Chair
Tori
G. Williams

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"Being in politics is like being a football coach. You have to be smart enough to understand the game and dumb enough to think it's important."

— EUGENE McCARTHY

Kentucky State Senate



Benny Ray Bailey D-29
PO Box 849
Hindman, KY 41822
(606) 785-3164 (H)
(606) 785-5327 (O)
Breathitt, Floyd, Johnson, Knott
Profession: Clinic Administrator
Education: Alice Lloyd College, AA; Pikeville College, BA; Indiana State U, MS; Ohio University, PhD
Committee Assignments: Appropriations & Revenue, State & Local Government



Walter Blevins Jr D-27
777 Broadway
West Liberty, KY 41472
(606) 743-1212 (H)
(606) 743-1200 (O)
Boyd, Elliott, Lawrence, Martin, Morgan
Profession: Dentist
Education: U of Kentucky, DMD
Committee Assignments: Transportation, Economic Development & Labor, Health & Welfare, Rules



Charlie Borders R-18
330 Seaton Drive
Russell, KY 41169
(606) 324-5755 (H)
(606) 836-1721 (O)
Carter, Greenup, Lewis, Mason, Robertson
Professon: Realtor
Education: Ashland CC; Southeastern Christian College; Morehead State U, BS, MBA
Committee Assignments: Banking & Insurance, Appropriations & Revenue

David E. Boswell D-8
2130 Woodland Drive
Owensboro, KY 42301
(502) 684-2490 (H)
(502) 771-4921 (O)
Daviess, Hancock
Profession: Hotel Sales Executive
Education: Western KY U; Brescia
Committee Assignments:
Transportation, Licensing & Occupations, Economic Development & Labor



Fred Bradley D-20
855 South Benson Road
Frankfort, KY 40601
(502) 564-2294 (H)
(502) 227-4443 (O)
Franklin, Henry, Jefferson, Owen, Shelby
Profession: Attorney, etc
Education: U of Kentucky, JD
Committee Assignments: Banking & Insurance, Rules, Licensing & Occupations



Tom Buford R-22
105 Crosswoods Place
Nicholasville, KY 40356
(606) 223-7171 (H)
Anderson, Boyle, Fayette, Jessamine, Mercer
Profession: Building Contractor
Education: U of K, BS; American Institute of Banking
Committee Assignments: Banking & Insurance, Health & Welfare, Rules, Licensing & Occupations



Lindy Casebier R-7
3304 Hardwood Forest Drive
Louisville, KY 40214
(502) 935-4085 (H)
Bullitt, Jefferson
Profession: Teacher
Education: U of L, MA
Committee Assignments:
Appropriations & Revenue, Banking & Insurance



Glenn Freeman D-17
PO Box 460
Cumberland, KY 40823
(606) 589-4438 (O)
(606) 589-5411 (H)
Bell, Harlan, Perry
Profession: Self-Employed, Property
Education: Cumberland College; Western KY U; U of K
Committee Assignments: Appropriations & Revenue, State & Local Government, Economic Development & Labor



Ernie Harris R-26
PO Box 1073
Crestwood, KY 40014
(502) 255-3392 (H)
Carroll, Gallatin, Grant, Jefferson, Oldham, Trimble
Profession: Pilot, Farmer
Education: U of K, Webster U, MM
Committee Assignments: State & Local Government



Paul Herron Jr D-4
2382 Wood Dr, Apt B
Henderson, KY 42420
(502) 826-6216 (H)
(502) 827-5480 (O)
Crittenden, Henderson, Livingston, Lyon, Union, Webster
Profession: Auctioneer/Realtor
Education: Indiana U
Committee Assignments: Health & Welfare, State & Local Government



Robert L. Jackson D-1
1108 County Cork
Murray, KY 42071
Calloway, Carlisle, Fulton, Graves, Hickman, Trigg
Profession: Marketing Company President
Education: Murray State U, BS
Committee Assignments: Banking & Insurance, Economic Development & Labor



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(606) 437-4002 (O)
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Letcher, Pike
Profession: Attorney
Education: Berea College, BS; U of K, JD
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Logan, Warren
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Committee Assignments: Rules, Licensing & Occupations, Judiciary



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Jefferson
Profession: Attorney
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Larue, Marion, Nelson, Spencer, Taylor, Washington
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Committee Assignments: Rules, Transportation, Licensing & Occupations



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Economic Development & Labor, Transportation



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Russell Springs, KY 42642
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Adair, Casey, Pulaski, Russell
Profession: Retired Educator
Education: Campbellsville College, BS; Western KY U, MA
Committee Assignments: State & Local Government



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Fayette, Garrard, Lincoln, Madison
Profession: General Contractor
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Committee Assignments:
Transportation, Licensing & Occupations



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Breckinridge, Grayson, Hart, Meade, Ohio
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Education: Eastern Kentucky U, BS
Committee Assignments:
Transportation, Appropriations & Revenue, Economic Development & Labor



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Committee Assignments: Transportation, Licensing & Occupations



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Bourbon, Bracken, Harrison, Nicholas, Scott, Woodford
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Committee Assignments: Appropriations & Revenue, Licensing & Occupations, Transportation



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Caldwell, Christian, Todd
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Committee Assignments: Appropriations & Revenue, Health & Welfare



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Committee Assignments: Judiciary, Health & Welfare, Licensing & Occupations



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Profession: Farmer, Restaurant Owner
Education: Western KY U .
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Committee Assignments: State & Local Government, Economic Development & Labor



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Hardin, Jefferson
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Committee Assignments: Health & Welfare, Judiciary



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Committee Assignments: Appropriations & Revenue, Economic Development & Labor, Rules



"Good legislation is in the eye of the beholder."

— CARL COOPER JR, MD
KMA PRESIDENT 1978-1979

House Leadership

ELECTIVE OFFICERS

Speaker	Jody Richards
Speaker Pro Tem	Larry Clark

PARTY LEADERS

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Caucus Chairman	James P. Callahan
Whip	Joe Barrows

Republicans

Floor Leader	Danny Ford
Caucus Chairman	Stan Cave
Whip	Woody Allen



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3 Frank Rasche
4 Kathy Hogancamp
5 Freed Curd
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7 John A. Arnold Jr
8 John W. Adams
9 James E. "Jim" Bruce
10 Joseph "Eddie" Ballard
11 Gross C. Lindsay
12 Jim Gooch Jr
13 Brian J. Crall
14 Mark A. Treesh
15 Brent Yonts
16 Sheldon E. Baugh
17 Willard C. "Woody" Allen
18 Dwight D. Butler
19 Dottie J. Sims
20 Jody Richards
21 Roger Thomas
22 Rob Wilkey
23 Stephen R. "Steve" Nunn
24 William U. Scott
25 Jimmie Lee
26 John Michael Weaver
27 Mark S. Brown
28 Vacancy
29 Kevin D. Bratcher
30 Thomas J. "Tom" Burch
31 Steven R. "Steve" Riggs
32 Susan D. Johns
33 Bob Heleringer
34 Mary Lou Marzian
35 Jim Wayne
36 Lonnie N. Napier
37 Perry B. Clark
38 Denver Butler
39 Robert R. Damron
40 Dennis Horlander
41 Thomas N. Riner
42 Eleanor Jordan
43 E. Porter Hatcher Jr
44 Joni Jenkins
45 Stanton "Stan" Cave
46 Larry Clark
47 Ronald E. Crimm
48 Bob M. DeWeese, MD
49 Allen Maricle
50 Joseph A. "Jodie" Haydon
51 Ricky L. Cox
52 Vernon Miniard
53 Billy D. Polston
54 Philip Joseph Clarke
55 Jack L. Coleman Jr
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58 Marshall Long
59 James F. Zimmerman
60 Paul H. Marcotte
61 Royce W. Adams
62 Charles R. Hoffman
63 Richard Murgatroyd
64 Thomas R. Kerr
65 Arnold Simpson
66 Charlie Walton
67 James "Jim" Callahan
68 Katie K. Stine
69 Jon David Reinhardt
70 Pete Worthington
71 John Will Stacy
72 Jim Lovell
73 Drew Graham
74 Adrian K. Arnold
75 Kathy W. Stein
76 Ruth Ann Palumbo
77 Jesse Crenshaw
78 Thomas M. McKee
79 Lawrence Brandstetter
80 Danny R. Ford
81 Harry Moberly Jr
82 Charles L. Siler
83 Jeffrey H. Hoover
84 Scott Alexander
85 Thomas J. Turner
86 Jim Stewart
87 Michael Dean Bowling
88 Thomas R. Pope
89 Marie L. Rader
90 Barbara W. Colter
91 Paul Mason
92 Donnie Newsome
93 Chris Ratliff
94 Herbie Deskins Jr
95 Greg Stumbo
96 Walter Gee
97 Hubert Collins
98 Hobart W. "Hoby" Anderson
99 Rocky Adkins
100 John F. Vincent

Committee Roster 1998 Kentucky General Assembly

HOUSE

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Eleanor Jordan
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Jon David Reinhardt

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Michael Bowling
Mark Brown
Jim Callahan
Stan Cave
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Danny Ford
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Porter Hatcher
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Marie Rader
Tommy Turner
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Mike Weaver
Rob Wilkey
Pete Worthington

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"The credit in life does not go to the critic who stands on the sideline and points out where the strong stumble, but rather, the real credit in life goes to the man who is actually in the arena, whose face may get marred by sweat and dust, who knows great enthusiasm and great devotion and learns to spend himself in a worthy cause, who, at best if he wins, knows the thrill of high achievement and if he fails, at least fails while daring greatly, so that in life his place will never be with those very cold and timid souls who know neither victory nor defeat."

— THEODORE ROOSEVELT

Kentucky's House Districts

Kentucky House of Representatives



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Transportation, State
Government



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Committee Assignments:
Appropriations & Revenue,
State Government, Rules



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Health & Welfare,
Licensing & Occupations



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Jefferson
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Education: U of L
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Committee Assignments: Labor & Industry



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Carter, Lewis
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Education: KY School of Embalming
Committee Assignments: Labor & Industry



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House of Delegates/Board of Trustees Legislative Policies

The KMA House of Delegates and the Board of Trustees have adopted policies on the following topics.

Any Willing Provider
Statutory Definition: "Health care benefit plans shall not discriminate against any provider, located within the geographic coverage area of the health benefit plan, willing to meet the terms and conditions for participation established by the health benefit plan." KMA supports retention of this statute.

Animal Research
KMA supports education of the public regarding the benefits of the use of animals in biomedical research; acknowledges its commitment to the humane treatment of animals used in biomedical research and the pursuit of alternative research models where appropriate; supports a minimum criminal penalty of a felony 4th class, for unauthorized removal of research animals and/or willful damage to research facilities and/or research projects.

Abortion
After the stage of viability, termination of pregnancy must be limited to those situations in which the life of the mother is jeopardized or a proven fetal anomaly exists. Abortion on demand is discouraged at any time; any live infant must be accorded the same rights and the same care that would be given to an infant delivered by more traditional means; the practice of using fetuses as experimental material is condemned; no hospital, clinic, institution, or any other facility in this state should be required to admit any patient for the purpose of performing an abortion nor required to allow the performance of an abortion; no person should be required to perform or participate directly or indirectly in an abortion procedure. No hospital, governing board, or any other person, firm, association, or group should terminate the employment or alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to participate in an abortion procedure.

Advanced Directives: Wards Of The State
Allow decisions to be made regarding advance directives and termination of inappropriate medical intervention in patients who are wards of the state, on a case by case basis.

Advanced Registered Nurse Practitioners
KMA supports the joint collaborative practice of physicians and ARNPs. ARNPs should be permitted to prescribe non scheduled drugs under written protocol and a formulary approved by the supervising physician and appropriate licensing authorities within closely defined geographic areas. ARNPs must complete established pharmacological prerequisites and maintain continuing education in the use of prescribed substances. The KMA opposes any effort by ARNPs to prescribe narcotics, opposes independent practice of ARNPs granted prescriptive privileges, and opposes any law or regulation that undermines the authority of physicians to determine patient care. The Kentucky Board of Medical Licensure (KBML) should develop regulations restricting the number of ARNPs with which a physician may have collaborative agreements. Physicians should individualize collaborative agreements based on the need of their patients and practice. KBML should develop criteria for collaborative agreements that safeguard patient care, including experience and educational background of the ARNP, appropriate referral patterns, quality assurance, and continuing education.

Alcohol
Warnings Against Use Of Alcohol During Pregnancy
Warning signs should be posted in all places where alcohol is sold that drinking alcoholic beverages during pregnancy can cause birth defects.
Driving Under The Influence Of Alcohol/Drugs
KMA supports lowering the allowable blood alcohol content (BAC) from 0.10 to 0.05 The KMA supports stricter enforcement of penalties for those convicted of driving under the influence of alcohol or drugs. Although less vogue than drug abuse, the drinking driver presents a much more serious threat to life and health in Kentucky.

Alcohol Use In Water Sports
The General Assembly should study the potential risks of unsafe operation of water jet skis, boats, and alcohol use in water sports and require adequate education and operation prior to use of such vehicles.

Brain Death
A physician in the exercise of his professional judgment

may declare an individual dead in accordance with accepted medical standards. Such declaration may be based solely on an irreversible cessation of brain function including the function of the brain stem.

Blood Alcohol Content (BAC)
Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.

Boat Safety
Legislation and regulations should be adopted to regulate water jet skis, boats, and alcohol use in water sports.

Bicycle Helmets
The KMA supports the enactment of legislation requiring bicycle riders to wear helmets while on streets or roadways.

Child Restraints
The KMA endorses the concept of mandatory child restraints in automobiles.

Continuing Medical Education (CME)
Mandatory Requirement
The KMA calls on all physicians to participate in CME in a formal manner and supports as a condition of Licensure, that physicians obtain 60 hours within each three-year period. Of the 60 hours, 30 must be in Category 1 credit, and 2 hours must be obtained from a CHS approved HIV/AIDS training course.
Disease/Topic Specific CME
The KMA opposes mandated "disease" and "topic-specific" CME and urges repeal of any and all statutory requirements for CME of specific diseases.

Certificate Of Need (CON)
Physician Offices
The KMA supports the preservation of the private physician's office exemption from CON and defends the control of physicians and their offices to remain with the Kentucky Board of Medical Licensure and it's statutory authority over the practice of medicine.
Mobile Units Operated By Physicians
KMA opposes efforts to extend regulatory power over mobile units operated by physicians.
Threshold Requirements
Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements. Exemption includes, but is not limited to, licensure, supervision, regulation, or control regulated by the state, except as physicians propose to purchase equipment which costs exceed $250,000.

Other Entities Covered By CON
KMA opposes exemptions based on geography, population, and number of acute hospital beds. KMA supports the retention of CON on nursing home beds.

Committee On State Legislative Activities (COSLA) Operating Procedures During The Kentucky General Assembly

(1) All state legislative proposals are to be coordinated by and channeled through COSLA.
(2) The composition, authority, and function of the Quick Action Committee (QAC) are retained.
(3) The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chair of COSLA and the QAC. The House of Delegates, recognizing the enormous task KMA faces as dramatic transformations are proposed in the health care delivery system which require immediate decisions, authorizes the QAC, in consultation with the KMA Executive Committee when indicated, to set legislative policies determined to be in the best interest of the Association, and to represent the Association in all matters. The Chair of COSLA shall keep membership of KMA, the House of Delegates, and the Board of Trustees fully informed as to the progress of legislative deliberations and provide to the membership details of KMA's plans and recommendations on becoming involved. The President of KMA is authorized to call emergency meetings of the KMA Board of Trustees as necessary, and special sessions of the House of Delegates in accordance with the Constitution and Bylaws if appropriate.

Campaign Financing
KMA opposes public financing of federal campaigns and limits on political action committee activities. Such control would limit participation in the political process and the political education benefits afforded by PACs.

Capital Punishment
KMA neither supports nor opposes the death penalty, recognizing that capital punishment is the personal moral decision of the individual. Physician participation in executions, except to certify cause of death, provided that the condemned has been declared dead by another person, is a serious violation of medical ethics. The KMA opposes any requirement for physician participation in execution except to certify death.

Commissioner Health Services
The Commissioner of the Bureau for Health Services should be a licensed, experienced, and qualified physician.

Credentialing
Quality improvement shall remain the primary purpose of the credentialing process involving physicians. The KMA opposes economic credentialing and political interference in the physician credentialing process.

Data Collection
The KMA supports repeal of provisions in HB 250, adopted in 1994, which require the submission of data from physicians offices or clinics.

Death
Death Penalty
(see Capital punishment)
Definition Of Death
Legislative and judicial intrusion into circumstances surrounding the possible death of critically or terminally ill patients should be kept at an absolute minimum. Decisions concerning the care of such patients should be left to the patient, their doctor and the patient's relatives in accordance with time honored customs. The patient's wishes in these matters should be of utmost importance and should be respected whenever possible. Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.
Model Uniform Death Act
KMA recommends the AMA model uniform death act. "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.
Death Certificates
The KMA urges physicians to promptly sign death certificates.
Driving Under The Influence
(see alcohol or BAC)

Drug Abuse
KMA will do everything within its power to lead the fight against drug abuse in Kentucky, not only in the case of abuse of amphetamines, but in the over-use, misuse, or abuse of any dangerous drug.

Do Not Resuscitate (DNR)
KMA supports a uniform, coordinated, and rational approach with respect to the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment in the pre-hospital environment. Physicians should be aware of the Kentucky EMS DNR order form and how it is to be used to minimize potential misunderstandings among physicians, EMS personnel, and affected family members. KMA supports the patient's right of self determination, as well as the health care professionals who follow such directives.

Dual Licensure Of Hospital Beds
The KMA endorses efforts of Kentucky Hospital Association in addressing the issue of dual licensure of hospital beds in Kentucky.

Education
Health Education
The KMA recommends that health education be taught to all students from Kindergarten to 12th grade, and affirms support for "parenting and family life skills education" curriculum in public schools.
Sex Education
KMA strongly supports sex education in schools, beginning in grades 5-7, recognizing that Kentucky has a very difficult and major problem with young adolescent pregnancies.
Physical Fitness Education
The KMA encourages uniform health education and physical fitness proficiency testing in all schools.
Sports Physicals
All physical examinations for participation in school-sponsored sports should be done under the supervision of a physician.
Anabolic Steroids
Students should be warned of the dangers of the use of anabolic steroids.
Athletic Trainers
The KMA encourages the State Board of Education where and when possible, to recommend to local boards of education the appointment of certified athletic trainers to work with physicians in the important area of health and supervision of athletes.
Ultraviolet Radiation Education
The KMA urges the State Board of Education to include in the curriculum appropriate information for teachers to educate students about hazards of ultraviolet radiation and tanning parlors.

Eye Care
The KMA recommends that legislation be enacted to require referral by nonphysicians to physicians, any person identified as an individual with suspected medical or surgical eye disease or medical conditions involving pathology of the eyes.

Euthanasia
The policy of the KMA concerning death and dying is totally opposed to any form of "active euthanasia."

Fireworks
The KMA supports the ban of all fireworks with the exception of approved professional displays.

Fees
Fee Setting
The KMA is opposed to governmental rate setting of physician fees and imposition of global budgets.
Inequitable Reimbursement
The KMA opposes payment differentials to physicians and hospitals based on geographic location. In the process of instituting single, equitable, statewide reimbursement schedules, insurance companies should not diminish any present reimbursement schedules.
Credit Cards
The use of a bank card in connection with the payment of larger fees—which might normally be paid in installments, is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges.

Gag Clauses
KMA supports efforts to ban "gag" and "hold harmless" clauses from contracts between managed care entities and physicians. All physicians are urged to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician.
Pregnancy Options Counseling
KMA opposes intrusion into the doctor-patient relationship by means of a "gag rule" limiting patient counseling in federally funded family planning clinics.

HIV Testing
Pregnant Women
The KMA recommends HIV testing of all pregnant women.
HIV And Physicians
The KMA opposes mandatory HIV testing for Physicians.

HIV Reporting And Confidentiality

KMA supports the enactment of legislation to: Prohibit discrimination against all persons infected with or perceived to be infected with HIV. Supports anonymous testing for HIV positivity where available. Supports requirement that confirmed HIV positivity is reported to the Department of health services and the local health department including at least the person's date of birth, race, sex, risk factor(s) and county of residence. Identification can be by patient's name and address if patient agrees, but must include as a minimum, a code assigned to the individual by the reporting physician which will always be the same for a given patient, but which in and of itself, will not identify the patient (such as patient's initials). Health workers are informed of a patient's positive HIV status if they are directly responsible for care of that patient.

Consent For HIV Testing

KMA supports legislation to provide that consent for treatment by a physician or a hospital shall also include the possibility of testing for HIV if deemed appropriate by the physician(s) involved in the care of that patient.

Release Of Medical Information

KMA supports the requirement that a positive HIV test result (confirmed Western Blot or equivalent) be deemed a Sexually Transmitted Disease (STD). KMA supports the authorization of the release of medical information to all medical personnel involved in the treatment of a patient who has a STD.

High Risk Newborns

(See Medicaid: High risk newborns)

Health Departments

Role Of Health Departments

The KMA affirms its support of local Boards of Health to determine the need of local citizens in public health measures, and urges its members who serve on local boards to actively participate. Discussions should be held on the local level between hospitals, health departments, and physicians to define the future role. The KMA opposes plans to provide routine unrestricted medical services through health departments, acute ambulatory services, and solicitation of private patients and provision of routine medical services by health departments. Health Departments should limit their endeavors to public health measures and not to the delivery of primary care.

Health Insurance

Standard Claim Form

KMA supports a standard, mandatory, and common claim form for all insurers.

Freedom Of Selection

KMA opposes restrictions on citizen's freedom of choice in selection of health insurance.

Obstetrical Care Coverage

The KMA reaffirms the patient-physician relationship and the ability of the physician to do what is in the best interest of the patient. In the absence of definitive empirical data, discharge following delivery should be determined by clinical judgment of physicians rather than health insurance guidelines. The KMA supports legislation that prevents third-party payers from interfering, by refusing to pay for care, with physicians' clinical judgment regarding patient care, including timing of discharge.

Insurance Coverage Of Medical Services

KMA supports payment for medically necessary services by insurers/payers based on the appropriate care of the patient. Decisions regarding insurance coverage of medical services should be considered separately for each service in question in the context of patient need and the physician's medical judgment.

AMA CPT Codes

The KMA supports statewide use of AMA CPT coding by insurance carriers.

Assistant Surgeons

The attending Surgeon is the individual best qualified to determine whether or not an assistant surgeon is needed. The physician serving as the assistant surgeon should be compensated fairly.

Hold Harmless Clauses

(see gag clauses)

Primary Care Physicians' Treatment Of Depression

KMA opposes reimbursement policies not paying primary care physicians for the outpatient treatment of depression or other mental health diagnosis.

Helmet laws

Motorcycle Helmets

Kentucky's mandatory motorcycle helmet law should be retained

Bicycle Helmets

KMA supports legislation requiring bicycle riders on Kentucky roads and streets to wear approved protective helmets.

Hospital Bed Dual Licensure
(See Dual Licensure of hospital beds)

Indigent Care
KMA recognizes that approximately 400,000 Kentuckians are uninsured. The Association proposes a plan based on Medicaid using the KenPAC approach, which offers basic medical services. Funding for the program may be obtained by taxes from various sources. The KMA supports additional funding for prenatal and pediatric care.

Indigent Medical Care Funding
Funding for indigent medical care should be obtained through the broadest possible spread throughout society as a whole. The KMA encourages State Legislators to study the statewide problem of indigent medical care and to assure adequate funding for the continued financial stability of the state teaching hospitals.

Insurance Commissioner
KMA opposes the concept of an "elected" Insurance Commissioner.

Involuntary Service Requirement
KMA opposes any legislative proposal that institutes an involuntary service requirement for physicians trained in Kentucky.

Joint collaborative practice with ARNP/PA
KMA supports the joint practice of physicians, Physician Assistants (PAs), and Advanced Registered Nurse Practitioners (ARNPs). The KMA supports legislation to permit PAs and ARNPs to prescribe nonscheduled medication under written protocol with the collaborating physician. There should be well-defined limits on the numbers of PAs/ARNPs a physician may supervise within closely defined geographic areas.

KENPAC
The KMA endorses the KENPAC program as outlined by the Cabinet for Health Services for Medicaid recipients. If appropriate, KMA will oppose by reasonable lawful means, any Medicaid managed care program proposed to supplant KENPAC unless improvement over KENPAC would result.

Laser Surgery
The use of laser equipment in surgery should be defined as the practice of medicine. Surgery is defined as any invasive procedure by any means which alters, penetrates, changes, or violates in any way human tissue, and includes preoperative and postoperative care for surgery. Appropriate exemptions should be established for den-

tists and podiatrists to the limit of their licenses, and exceptions granted to Nurses and other health personnel to perform routine patient care activity such as injections, routine testing, etc, as prescribed by the attending or consulting physician. The KMA opposes any legislation or administrative proposal to permit nonphysicians to perform laser surgery.

Listening Devices
KMA supports legislation to restrict the use of personal listening devices by joggers and bicycle riders using public thoroughfares.

Lap Shoulder Harness
KMA supports mandatory use of lap-shoulder belt systems in Kentucky motor vehicles

Medical Directors
Medical Directors of insurance companies, health maintenance organizations, and managed care networks serving patients in Kentucky should be required to be licensed in Kentucky under jurisdiction of the Board of Licensure. Managed care organizations and employees who make decisions which result in patient injury should be held legally responsible for their decisions.

Medicaid Regional Partnerships
The Cabinet for Health Services should limit implementation of privatization methodologies to one, or perhaps two, pilot projects. Based upon reported activities, it appears such pilot projects are centered in regions 3, 5, or both. The KMA suggests that while other areas of the state may wish to develop an infrastructure capable of supporting a managed care partnership, actual implementation of this strategy should be held in abeyance until pilot projects clearly demonstrate their value to the Commonwealth.

Medicaid
Reimbursement/funding
KMA actively promotes a reasonable reimbursement rate for Medicaid providers, and stands for adequate and broad-based state general funding for the Medicaid program. KMA is opposed to shifting Medicaid funds to balance the general budget.
High Risk Newborn
All high-risk newborns eligible for Medicaid should be followed by their physicians, their designees, and/or visited by a public health nurse to ensure PKU testing; metabolic screening; access to a primary care provider; infant immunizations; access to the WIC program where indi-

cated; implementation of application for newborn under Medicaid; and repeat pregnancy education.

Privatization Of Medicaid

Any substantial revision structure of Medicaid must retain assurances that the plan be able to enlist enough physicians so that care and services are available to the general population. If proposed revisions are not in the best interest of patients and physicians appropriate legal, judicial, legislative, or administrative actions will be taken.

Equitable Payments To All Specialties

Reimbursement methods should not discriminate against any class or specialty of physicians. KMA urges CHS to examine the Medicaid reimbursement policy, and this policy should reflect reimbursement levels proportionate to charges and level of skill and training, regardless of physician location or specialty.

Mandated Service Requirement

(see involuntary service requirement)

Medical Records/X-RAYS

Medical records and X-rays are the property of physicians. Copies of records and X-rays should be available for an appropriate fee that permits providers to recover administrative and actual copying expenses. KMA supports repeal of the requirement that physicians provide free copies of medical records. However, medical records should be forwarded to a different or new attending physician upon proper request.

Medical Laboratories

Medical laboratories operated by a licensed physician or group of licensed physicians, solely and exclusively in connection with the diagnosis and treatment of their own patients, should be exempt from state provisions governing laboratories. If any referred work is received or performed by such medical laboratories, all provisions of the act should apply.

Medical Waste

KMA condemns the disposal of hazardous medical waste in any fashion which might be harmful or dangerous to humans, animals, or the environment. Guidelines and/or regulations governing the disposal of hazardous medical waste materials should be developed.

Medical Education Funds

KMA opposes reallocation of human, financial, and academic resources currently available for medical education toward an additional allopathic, osteopathic, public or private medical school.

Mental Health Benefits
KMA supports the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other medical or physical illnesses.

Medicare Supplement Insurance
Medicare supplement policies should be standardized, and consistent with model regulations developed by the National Association of Insurance Commissioners. All supplements should pay all or none of the Part A deductible, and pay at least 20% of Part B provider copayments, regardless of location of care. HMOs should not be exempt from these provisions.

Managed Care
Managed care is designed to reduce costs and maintain quality of medical care. A system should be developed to monitor managed care and assure patients' decreased costs, along with quality of medical care.

Medical Examiners
KMA supports the expansion of the medical examiners system throughout the state of Kentucky. The Department of Justice should formulate a plan to improve medical/legal death investigation in the Commonwealth to include appropriate state fiscal support to implement such a plan.

Motorcycle Helmets
The mandatory motorcycle helmet law should be retained.

Nursing Home Beds
KMA urges the Kentucky General Assembly to appoint a task force to study the issue of the limited supply of extended beds in Kentucky.

Non Physician Practitioners
KMA opposes additional licensure of health care workers. Certification of health care personnel should be considered on a case-by-case basis. Enhancement of practice acts by nonphysician practitioners, through legislative fiat rather than education, is inappropriate.

Optometrists
KMA opposes legislation allowing optometrists to act or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery. The KMA opposes any legislation granting optometrists the right to prescribe or apply medications, or to diagnose disease or injury, or to diagnose the absence of disease or injury.

Ophthalmologists
Ophthalmologists shall be regarded as comprehensive (primary, secondary, and tertiary) eyecare providers.

Patient Right Of Determination
KMA supports legislation or regulation that protects "patient's right of determination" and the activities of health care professionals who follow such directives.

Provider Tax
The KMA opposes the provider tax and recommends repeal.

Provider Sponsored Networks
The KMA supports the establishment of provider sponsored networks and recommends that financial solvency reserves be different than required of HMOs and other risk-bearing insurance entities.

Primary Care Physicians
Obstetricians
Obstetricians should be regarded as primary care physicians to their obstetrical patients during the perinatal period.
Ophthalmologist
Ophthalmologist shall be regarded as comprehensive (primary, secondary, tertiary) eyecare providers.

Patient Protection Provisions
The KMA supports the priority of patient welfare in all managed care programs and the rights of patients to be advised. The KMA advocates state laws that provide for patient protection and physician fairness in managed care organizations.
Rights Of Patients In Managed Care
- Services covered or excluded under a health plan printed in easily understood language.
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage.
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services.
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care.
- Patients ability to continue treatment with their provider of choice during the period of enrollment.
- Patients ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the pro-

vider's participating status in such plan with no post treatment denial.
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues.

Patient Protection And Physician Fairness In Managed Care
- Permit physicians to negotiate with managed care organizations, as appropriate.
- Provide for formal practicing physician input in the development and refinement of medical policies, including credentialing, utilization review, quality assurance, and benefit package.
- Require disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or deselection.
- Provide enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered.

Point Of Service
KMA advocates a point-of-service feature requirement in all managed care plans which have a closed panel.

Public Financing Of Campaigns
(See campaign financing)

Prescription Drugs By Mail
The KMA should take reasonable steps to prevent the prescribing of large quantity mail orders for scheduled drugs or other drugs with abuse potential. The KMA should take steps to make the detrimental aspects of large quantity mail order prescriptions known to the purchasers and users of these drugs in an attempt to diminish this activity.

Patient Diagnosis On Prescriptions
The KMA opposes any effort to require patients diagnosis on prescriptions. Such proposals create numerous concerns, including confidentiality.

Physician Assistants (PA)
KMA supports the joint collaborative practice of physicians and physicians assistants in which PAs are supervised by licensed physicians. The KMA endorses legislation permitting PAs to prescribe, dispense, and order nonscheduled medications in accordance with the discretion and responsible oversight of the supervising physician. Health care services provided by the PA should be reimbursed to the supervising physician. The

KMA urges the CHR to reimburse PA services rendered to Medicaid patients.

Physician Extenders
KMA supports certification of physician extenders by the Kentucky Board of Medical Licensure. The Board shall have responsibility of determining the qualifications of all such personnel and the parameters of practice on an individual basis to licensed physicians who may utilize such personnel.

Physician Fees
(See fees)
Rate Setting
(See fees)

Political Action Committees (PAC)
(See campaign financing)

Rape Victims
KMA supports legislation that would prohibit the news and print media from making public the names of rape victims.

Respiratory Therapists
KMA supports the mandatory certification of respiratory therapists under the auspices of the Division of Occupations and Professions.

Riding in Rear Of Open Trucks
KMA supports legislation prohibiting all persons not of the age of majority in the Commonwealth from riding in the rear of open trucks.

Seat Belts
KMA supports the mandatory use of seat belts. All passengers in moving vehicles should be required to use safety belts.

Sex Education
(See education)

Statewide Fee Schedule
(See fees)

Telemedicine
The KMA recommends that in the best interest of the health and safety of the citizens of Kentucky that all non-resident physicians practicing telemedicine in Kentucky be required to have a full and unrestricted license to practice medicine in this state.

Tobacco
The KMA recommends:
- All Hospitals and clinics should prohibit smoking within their buildings.

- Designation of all restaurants as smoke-free, or at least the creation of adequate nonsmoking area.
- Oppose use of tax dollars to finance efforts, including lawsuits, aimed at overturning or postponing FDA regulations re: tobacco.
- Encourages physicians to intensify educational efforts directed to patients on the deleterious effects of tobacco use.
- Encourages the Kentucky General Assembly to increase its attention to the serious health problem of tobacco product use and the trend of teenage smoking.
- Increased fines for illegal tobacco sales to minors.
- Allow standard law enforcement agencies to enforce sales restrictions for children.
- Permit local communities to pass more stringent laws if they feel appropriate.
- Legislation prohibiting the sale of tobacco to individuals under 18 years of age.
- Opposes use of billboards or other mediums which advertise tobacco products visible from school property.
- Enactment of a clean indoor air standard, applicable to all public buildings and all buildings open to public access, which restricts smoking to designated areas which are separately vented to the outside.
- Require all school districts to ban smoking and use of tobacco products from all school buildings, property, and school sponsored events involving students.
- Ban the sale of tobacco products in vending machines except to areas off limits to minors or operated with tokens which can be acquired only by adults.
- Include tobacco use rates and tobacco related knowledge levels as evaluation criteria for schools under the framework of education reform.
- Ban tobacco company sponsorship of athletic events in which youth are involved.
- Provide that in order to sell tobacco products, a retailer must have a license (similar to a liquor license) which can be revoked for sale to minors.
- Ban distributions of free tobacco product samples altogether as part of retail license requirements.
- Restrict tobacco advertising to black and white printed text without pictures (the tombstone law), if permissible under federal law.
- Repeal the "smokers' rights" provisions which forbid consideration of smoking practices as a legitimate factor in employment decisions.

Taxes
Provider
The KMA opposes the provider tax.
Cigarette/Tobacco
KMA supports increases in the tax on tobacco in order to lower the number of new teenage smokers. Funds raised through increased tobacco tax should be used to fund health care in Kentucky, and to fund the development of agricultural alternatives to growing and processing of tobacco and tobacco products.

Tax Free Income For Services To Medicare/Medicaid Patients
KMA supports legislation exempting physicians' income earned from providing services to Medicare and Medicaid patients in rural and underserved areas from federal and state income taxes.

Tort Reform
The KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards.

Ultraviolet Radiation
(See education: Ultraviolet radiation)

Uninsured
(See indigent care)

Vision Testing For Drivers License
KMA supports periodic retesting of vision, preferably at the time of each quadrennial drivers license renewal. The KMA should carefully consider any legislation regarding the requirement for such retesting and take action as appropriate.

Water Sports And Safety
(See alcohol use in water safety)

Wards Of The State
(See Advanced Directives: Wards of the state)

Workers Compensation
Kentucky physicians offices and clinics employ approximately 40,000 Kentuckians and KMA is mindful of the increasing costs of workers compensation insurance. Physicians are equally concerned with their patients and access to quality medical care and appropriate benefits when injured on the job. Worker Compensation laws should be fair and equitable and strike a delicate balance which should be beneficial in the long term to both employee and employer.

X-rays
(See Medical Records, X-Rays)

Legislative Terms and Definitions

The following terminology may be helpful to you in your involvement with legislative process.

Acts — the volume of bills enacted at one session; published by Legislative Research Commission

Adjourn (motion to) — an action to discontinue proceedings for the day; a privileged motion non-debatable, not subject to amendment, and requiring for its adoption the assenting votes of a majority of the members present and voting

Adjournment Sine Die — adjournment "without a day"; this action ends a session, since no time is set for reconvening; this type of adjournment may occur at any time during a session

Administrative regulation — an enactment of law by an executive-branch agency or department, under authority granted by the General Assembly

Administration bill — legislation introduced at the behest of an executive-branch agency or department, usually sponsored by the majority floor leader

Adoption — approval or acceptance; usually applied to resolutions or amendments

Amend (motion to) — an action to modify the contents of a bill or question under consideration; the motion to amend is in order at any time prior to final passage, unless the previous question has been ordered

Amendment — any alteration made or proposed to be made in a bill, motion or clause thereof, by adding, substituting or deleting

Committee — a group of legislators, usually members of the same house, assigned to consider some issue or question and submit a report on its recommendations for action by the body which created it

Committee amendment — an amendment to a bill which is attached to the bill by a committee and made a part of the committee's report on the bill

Conference Committee — a joint committee of senators and representatives directed to reach agreement on legislation on which the two houses are unable to agree

Committee, interim joint — a committee composed of all members of a Senate standing committee and all members of a House standing committee, which meets between sessions as a subcommittee of the Legislative Research Commission

Committee substitute — a bill offered by a committee in lieu of a bill it has considered; technically, the committee substitute is an amendment to the original bill

Companion bill — a bill which is identical to a bill having been introduced in the opposite house

Concur — action by one house to agree to modifications of its legislation by the opposite house

Consent calendar (or consent orders) — a list of bills having had one (or two) reading(s), and on which members in attendance are presumed to vote yes unless they indicate a negative vote prior to the call of the roll

Constitutional majority — one more than half of the members of deliberative body

Co-sponsor — a sponsor of a bill or resolution who is not the principal sponsor

Effective date — the date on which a legislative measure begins to function as a part of the law; in Kentucky, most legislation becomes effective 90 days after sine die adjournment

Emergency clause — provision in a bill that it become effective immediately upon approval by the governor rather than the 90 days after adjournment

Enrollment — the act of comparing a printed bill to be transmitted to the governor with the original; introduced bill with all amendments, so as to ascertain their identical form

Floor — the area of a legislative chamber which is occupied by the members and staff of the body

Floor amendment — an amendment filed with the clerk to be considered on third reading of the bill to which it has been filed

General orders — a list of measures eligible for debate, amendment and voting on a given day, without reference to a particular time of day or place in the order of business

Hopper — colloquial name given the repository for bills awaiting introduction; in Kentucky such bills are filed with the clerk

House — one body of deliberation in a legislature; customarily a shortened name for the House of Representatives

Interim — the period of time between sessions of a legislature

Introduction — the presentation of a bill or resolution to the legislative body for its consideration

Joint sponsorship — a procedure in the Kentucky House of Representatives whereby several members may sponsor legislation without one being a "principal" sponsor, and each bearing equal responsibility as endorsing the measure

Kentucky Revised Statutes — the official title of statute law in Kentucky; each bill creates, amends, or repeals a section of the KRS

Lay on the clerk's desk (motion to) — an action to place a measure in a position of temporary postponement

Lay on the table (motion to) — an action to declare a measure defeated

Majority caucus chairman — a member affiliated with the majority party, who is responsible for convening the caucus of his party and presiding over its deliberations

Majority floor leader — a member affiliated with the majority party, designated to act for the party during the proceedings on the floor

Majority party — the political party whose members occupy at least one more than half of the total membership of the body

Majority whip — a member affiliated with the majority party, designated to assist the floor leader during proceedings on the floor

Passage — the approval of a bill or resolution by way of an affirmative vote

Postpone indefinitely (motion to) — action to prevent consideration of a measure for the remainder of the session, unless a constitutional majority sustains a motion to reconsider the matter

Postpone a fixed time (motion to) — to defer consideration of a question until a time specified in the motion

Prefiled bill — a bill filed prior to the session, for public discussion and printing

President — the presiding officer in the Senate

President pro tempore — the Senator, elected by the Senate, chosen to preside in lieu of the President when such officer is absent or unable to preside

Quorum — the number of members of a legislative body which must be present to transact business

Reading — each bill to be enacted in Kentucky must have three readings, at length, in each house

Recommit (motion to) — action to send a measure to committee after it has been previously reported

Reconsider (motion to) — action to re-take a vote; the motion may be offered only by a member having voted previously on the prevailing side

Refer — to send a measure or question to committee

Resolution, concurrent — expression of opinion or request by both houses of a legislature, without the force of law

Resolution, joint — to enact matters of law not to be made a portion of the statutes

Resolution, simple — expression or request by one house

Revision — the process of inserting the enactments of a session into existing statute law

Roll call — to determine a vote on a question by taking of names in favor and opposed

Section — a division of a bill or statute, separated according to topic covered or action taken

Session, extraordinary — a session convened by call of the Governor

Session, regular — a session convened on a regular basis by way of constitutional provision as to its date and length

Simple majority — a majority of those voting on a question

Speaker — the presiding officer of the House of Representatives

Speaker pro tempore — the member of the House of Representatives selected to preside in the absence or inability of the Speaker

Special order — an action predetermined to occur at a specific time on a specific date

Stopping the clock — an occasional tactic on the final evening of a regular session whereby the proceedings continue into the following day, with the clock and journal continuing to indicate occurrences of action of the preceding day

Sunset legislation — a law requiring termination of a particular agency or program on a predetermined date, unless justification for continuance is presented to the legislature prior to such occurrence

Suspend the rules — action to negate the application of a particular rule of procedure; the rule and purpose must be stated in the motion to suspend

Veto — rejection of an enactment without authority to modify; usually the prerogative of the Governor

Veto override — authority of the legislature to overturn a rejection of legislation by the Governor

Voice vote — a method of voting whereby only a vocal response to a question is indicated

Vote — a decision on a question by a member of a deliberative body, either affirmative or negative

Withdraw — to recall, remove or delete a question from consideration

Medicaid

Historically, Medicaid payments to physicians have been lower than other third party payors. Rates were based on an arcane formula that often produced fees that barely covered costs. Regardless, KMA understood the limitations of Kentucky's budget and accepted payment rates as they were developed by the state. KMA did not actively lobby the budget making process. We realized that more and more services were being mandated by the federal government, that the universe of people eligible for the program was constantly expanding, and that long term care for the elderly was becoming an increasingly difficult problem.

Medicaid physician payment rates remained essentially unchanged from 1978 through 1988. There was a small increase in 1989 for obstetrical and pediatric care driven by the federal Boren Amendment. On July 1, 1990, there was a slight overall increase for all other physicians.

During the 1991 Special Session, HB 21 instituted a tax on, among others, "fee for service" providers. As HB 21 became law in Kentucky, Medicaid payment rates changed and physicians realized a substantial increase in their payment rates. Physicians also paid a 15% tax on revenues generated from the Medicaid program. At the same time Kentucky, and the Medicaid program specifically, profited from the provider tax. For every $4.00 raised, Medicaid kept $2.00 and this occurred without use of general fund dollars.

In 1991 physicians began to see new tax dollars flowing into the Medicaid program. Half of those dollars, right off the top, went to help the program generally. Other monies brought to a reasonable level, rates that had not been updated for ten years. This made participation in the Medicaid program more attractive to physicians and enhanced access to care for Medicaid eligible patients.

A Special Session of the General Assembly in May 1993, enacted HB 1, which levied a 2% tax on physician services. Physicians were prohibited from passing on this tax to the recipient of the health care services. The express purpose of this tax was to help fund the Medicaid program, which was described by the Administration as "nearly bankrupt." In the summer of 1993, shortly after the tax was enacted, Medicaid announced a $139 million budget surplus. Despite this surplus, physician reimbursement did not increase nor was implementation of the tax halted.

The 1994 General Assembly included a 2% provider tax as part of HB 250, Kentucky's so-called health systems reform measure. This tax was sold to physicians as the only alternative to keep Medicaid solvent and reimbursement at a reasonable level. Shortly after this tax was enacted, physician Medicaid reimbursement was slashed some $52 million. Despite a legal challenge, these cuts remain in effect.

Kentucky physicians receive approximately 12 cents of the Medicaid dollar, compared to 19 cents of the health care dollar

spent nationally. Despite Medicaid's historically low reimbursement rate and the provider tax, KMA has consistently urged physicians to participate in the program and treat patients regardless of their ability to pay. The Association has been the cornerstone of the Kentucky Physicians Care Program which has referred over 55,000 patients to physicians who have treated them without charge. Over 60% of KMA members participate in the KPC program with over 250,000 physician/patient encounters.

Kentucky physicians have made a strong and positive contribution to caring for Kentucky's poor. Our activities with respect to Medicaid and the Kentucky Physicians Care Program attest to that.

Medicaid Facts

- Most physicians receive less than $5,000 per yr (59.9%)
- Nearly 70% receive less than $10,000 per year
- Many physicians receive $25.00 or less per patient
- Drs rank 24th of 44 providers in average pay per patient
- Physicians are paid less than transportation providers
- Physicians receive only 14% of Medicaid expenditures
- Physicians treated 2,110,559 Medicaid patients in 1994
- High usage = misleading "total physician payment" figure
- % of Drs with large Medicaid practices is minuscule
- Only 208 (3.5%) received $100,000 or more in FY 1994

In 1995, Kentucky received permission from the federal government to move the state's Medicaid system into a new managed care program. This is a unique project unlike any other in the country. The state is essentially turning the Medicaid program over to Kentucky's medical providers by dividing the state into eight geographic regions, with each region having its own infrastructure and program, called "Partnerships." The state will pay each region a per member-per month fee to fund the operation of each Partnership. Two Partnerships, which encompass Louisville and Lexington, have already developed the necessary infrastructure to manage their Medicaid populations.

The KMA has expressed its concerns about this new system to the administration, which center around the difficulty of forming managed care entities in rural areas of the state where there has been little managed care penetration. The KMA has also asked that the project be put on hold in the rest of the state while Louisville and Lexington have time to operate and all can see how they work before such a system is imposed on the rest of the state. The state has said that if a region does not form a Partnership, the Medicaid system in that region will be put "up for bid" to private industry. But, the state has also said it will not take such action until 1999.

Provider Tax

Between 1991 and 1993, Kentucky obtained a portion of funding for its Medicaid program through a tax on physicians. This taxing mechanism was known as HB 21. This tax was imposed only on physicians voluntarily participating in the Medicaid program, and was equal in amount to one-half (1/2) of the increase in revenues realized by the participating physician as a result of the July 1, 1991, Medicaid fee update (not to exceed 15% of the physician's gross Medicaid revenue for each calendar quarter). The Kentucky law further provided that any Medicaid participating physician would be reimbursed for the entire amount of the tax from the Medicaid fund. Thus, the physicians and other health care providers serving Medicaid patients were held harmless for the tax.

Under a 1991 amendment to federal law, the amount of state expenditures recognized by the federal government for purposes of determining matching funds was reduced by the amount of any health care related tax found to be impermissible under the amendment. Under this amendment, a state health care related tax is permissible if it is broad based, uniformly imposed, and does not hold the state health care taxpayers harmless for their tax costs.

Kentucky's tax on health care professionals, as it existed under the HB 21 taxing mechanism, constituted an impermissible state tax for purposes of the 1991 amendment since it purported to hold taxpayers harmless for the tax. The effect of this impermissibility was to risk that portion of Kentucky's Medicaid expenditures based on the tax on health care professionals (including physicians) participating in Medicaid. Any impermissible tax receipts would be disregarded by the federal program, which in turn would mean a reduced level of matching funds to fund Kentucky's Medicaid program.

The intent of the 1993 Special Session of the General Assembly in enacting HB 1 was to impose a tax on health care providers in a manner consistent with the 1991 amendment to federal law, in order to maintain the state's level of Medicaid expenditures so as not to suffer a reduction in the level of federal matching funds.

HB 1 imposed a 2% tax on the gross revenues of providers of physician services, nursing facility services, intermediate care facility services for the mentally retarded, home health care services, and health maintenance organization services. Physicians were specifically pro-

hibited from passing this tax on to the recipient of the health care services.

Prior to the implementation of HB 1 on July 1, 1993, the KMA Board of Trustees voted to mount a legal challenge to the constitutionality of this law. This tax was ultimately determined to be constitutional by the state and federal courts.

The Kentucky General Assembly, during its 1994 Regular Session, included a provider tax provision in HB 250. This tax replaced the HB 1 version of the provider tax on July 15, 1994. This provider tax is imposed on physicians at a rate of 2% on gross revenues. "Gross revenues" is defined as a total amount received in money or otherwise by a provider for the provision of health care items or services in Kentucky, less certain exemptions.

Conspicuous by its absence in the HB 250 version of the provider tax is a prohibition on passing the tax on to the recipient of the service or any third party. For all practical purposes, this silence has been interpreted to mean that physicians cannot pass the tax on to the recipient of health care services.

KMA has always opposed a provider tax. Reliance on such a mechanism as a long-term, stable source of funding for an ever-expanding Medicaid program is not logical. Kentucky physicians already subsidize a substantial portion of the cost of health care for the indigent. Physicians routinely treat not only Medicaid patients, but also patients who have no insurance, and they will continue to do so regardless of the patient's ability to pay. Physicians stand ready to contribute their "fair share," but to shoulder the entire burden is unfair.

Provider Tax Facts

- Physicians pay 24% of amount collected through tax
- Physicians receive only 14% of Medicaid expenditures
- Assessment exceeds 4% of most physicians Net Income
- Tax paid exceeds fees received for most physicians
- Physicians not in Medicaid program must pay tax
- KY is 1 of only 3 states with provider tax on physicians
- Only KY & W. WA levy tax on gross receipts
- Tax is a negative for physician recruitment

KMA — The Kentucky Medical Association established the repeal of the physician component of the provider tax as its major objective. The 1996 Kentucky General Assembly responded and adopted House Bill 397 which incorporated a phase out of the tax over a three year period. The tax will be totally repealed effective August 1, 1999.

Medical Liability — *A History of Legislation in Kentucky*

During the mid-1970s, Kentucky, like many other states, was caught in a medical liability crisis. The market for professional liability coverage began to shrink. If coverage was available, its price was prohibitive.

When the General Assembly convened in 1976, Kentucky legislators were acutely aware of the problem. At KMA's request, a special task force appointed by the Governor studied the situation for months.

Kentucky's General Assembly responded in 1976 by passing legislation which:

• Eliminated the Ad damnum clause • Provided that an advance payment could not be used as evidence to show admission of liability on the part of the physician or the insurance carrier • Adopted the Statute of Frauds, allowing no liability for guarantees unless submitted to the patient in writing • Codified informed consent into law • Ensured the confidentiality of peer review • Established a patient compensation fund, requiring all physicians and hospitals to belong • Created a joint underwriting association for providers to obtain coverage • Required reporting of all claims, settled or adjudicated, to the state Insurance Commissioner.

In 1977, the Kentucky Supreme Court ruled that provisions relating to the creation and maintenance of the Patient's Compensation Fund were unconstitutional. The Court also declared that the amendment establishing peer review confidentiality was unconstitutional because the amendment was not germane to the title of the enacting legislation.

The 1978 General Assembly re-enacted legislation regarding peer review confidentiality.

In 1978, the Kentucky Medical Association founded Kentucky Medical Insurance Company. Today, it insures approximately 50% of Kentucky's practicing physicians.

In 1980, the liability crisis reappeared, and KMA sought legislative relief from the 1986 General Assembly. The KMA supported legislation to limit awards, limit noneconomic awards, reduce statute of limitations for minors, and establish periodic payments. None of the KMA-supported measures were passed.

In 1988, the KMA joined with over 20 professional and business organizations to present legislation to resolve the liability crisis. The legislation included proposals to modify the tort system and strengthen insurance laws and regulations. The reform legislation included the following tort reforms relating to physicians liability claims:

- **Joint and Several Liability**
- **Standards of Conduct for Punitive Damages**
- **Collateral Source Rule**
- **Standards of Conduct for Officers and Directors of For-Profit Corporations and Officers, Directors, and Volunteers of Non-Profit Corporations and Charitable Organizations**
- **Confidentiality of Peer Review Records**
- **Antitrust Immunity for Peer Review and Centralized Reporting of Liability Claims**

KMA Legislative Goals

Patient Protection

The KMA supports the priority of patient welfare in all managed care programs and the rights of patients to be advised. The KMA advocates state laws that provide for patient protection and physician fairness in managed care organizations.

Rights Of Patients In Managed Care

- Services covered or excluded under a health plan printed in easily understood language.
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage.
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services.
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care.
- Patients ability to continue treatment with their provider of choice during the period of enrollment.
- Patients ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the provider's participating status in such plan with no post treatment denial.
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues.

Patient Protection and Physician Fairness In Managed Care

- Permit physicians to negotiate with managed care organizations, as appropriate.
- Provide for formal practicing physician input in the development and refinement of medical policies, including credentialing, utilization review, quality assurance, and benefit package.
- Require disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or deselection.
- Provide enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered.

Point Of Service

KMA advocates a point-of-service feature requirement in all managed care plans which have a closed panel.

Tort Reform

KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards.

Section 54 of Kentucky's Constitution states,

"The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."

The KMA proposes the following amendment to Section 54:

"The General Assembly shall have no power to limit the amount to be recovered for economic loss, including medical expenses, property damage, and lost earnings arising from injuries resulting in death, or for injuries to person or property. The General Assembly shall have the power to limit the amount to be recovered for noneconomic loss, punitive damages, and all other nonpecuniary damage arising from injuries resulting in death or from injuries to person or property. The General Assembly shall also have the power to prescribe the manner in which damages shall be paid.

Talking points in support of limits on noneconomic Limits:

- A 1995 survey indicated that almost two-thirds of Kentucky voters favor limiting noneconomic damages in civil lawsuits. Only 27% opposed.
- A cap on noneconomic damages in no way takes away a patient's right to sue in the event of a medical injury. Injured patients should be compensated for the cost of their care, present and future wages and other economic losses. Patients have an unequivocal right to be made whole.
- No other developed country compensates victims of health care injuries as generously for their noneconomic losses. Even with a cap of $250,000, we would be the most generous country in the world in terms of noneconomic damage awards.
- The Physician Payment Review Commission in it's 1994 Report to the Congress stated that "Much of the unpredictability and inconsistency that characterize today's malpractice awards is because of noneconomic damages (i.e. pain and suffering), which account for about 50% of total payments. Approximately half of the states have statutory limits on noneconomic damages.
- According to the Danzon study a cap on noneconomic damages reduced claims severity 23% on average over the decade in which claims were studied.
- The GAO found that just 2% of medical liability cases

produce the large awards for "pain and suffering" damages, yet these cases accounted for over 60% of the payouts.

- According to the Office of Technology Assessment (OTA) limits on noneconomic damages are the single most effective reform in containing medical liability premiums.
- Prior to enactment of a $250,000 ceiling on noneconomic damages in California, the state had the highest liability premiums in the US. California's premiums are now one third to one half of those in New York and Florida and other states without limits.
- According to the Institute of Medicine study, the delivery of obstetrical care in all rural areas is seriously threatened by professional liability concerns.
- According to a RAND Corporation study plaintiffs keep only 43 cents of every dollar spent on medical liability. The remainder goes to lawyers.
- A cap on noneconomic damages encourages more expeditious resolution of cases. Settlements should be encouraged rather than continuing the "lottery mentality" which favors lawyers by awarding arbitrary and unpredictable noneconomic damages.
- 71% of Americans support limits on noneconomic damages according to a 1995 poll.
- 77% believe malpractice lawsuits are an important reason for the rising costs of health care.

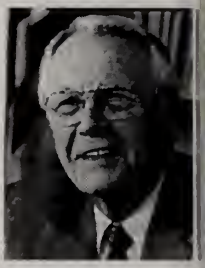
Health Education and Vehicular Safety

- The KMA recommends that health education be taught to all students from K–12.
- The KMA supports sex education in schools beginning in grades 5-7.
- The KMA encourages uniform health education and physical fitness proficiency testing in all schools.

KMA supports the adoption of laws to save lives and reduce medical costs:

- Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.
- All passengers in moving vehicles should be required to use safety belts.
- Periodic testing of vision should be required at the time of driver's license renewal.
- Minors should not be permitted to ride in the rear of open trucks.
- Mandatory motorcycle helmet laws should be retained.

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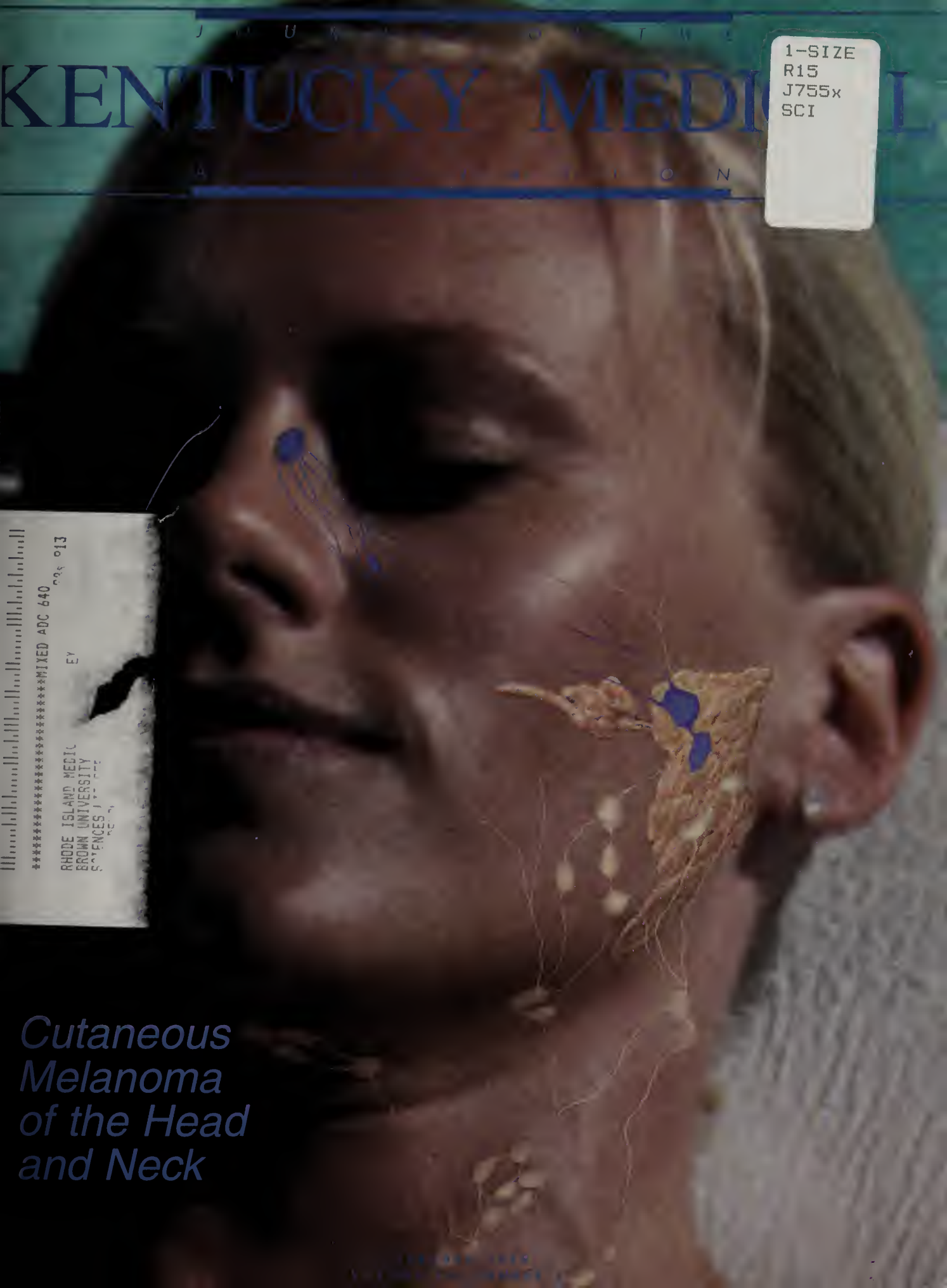
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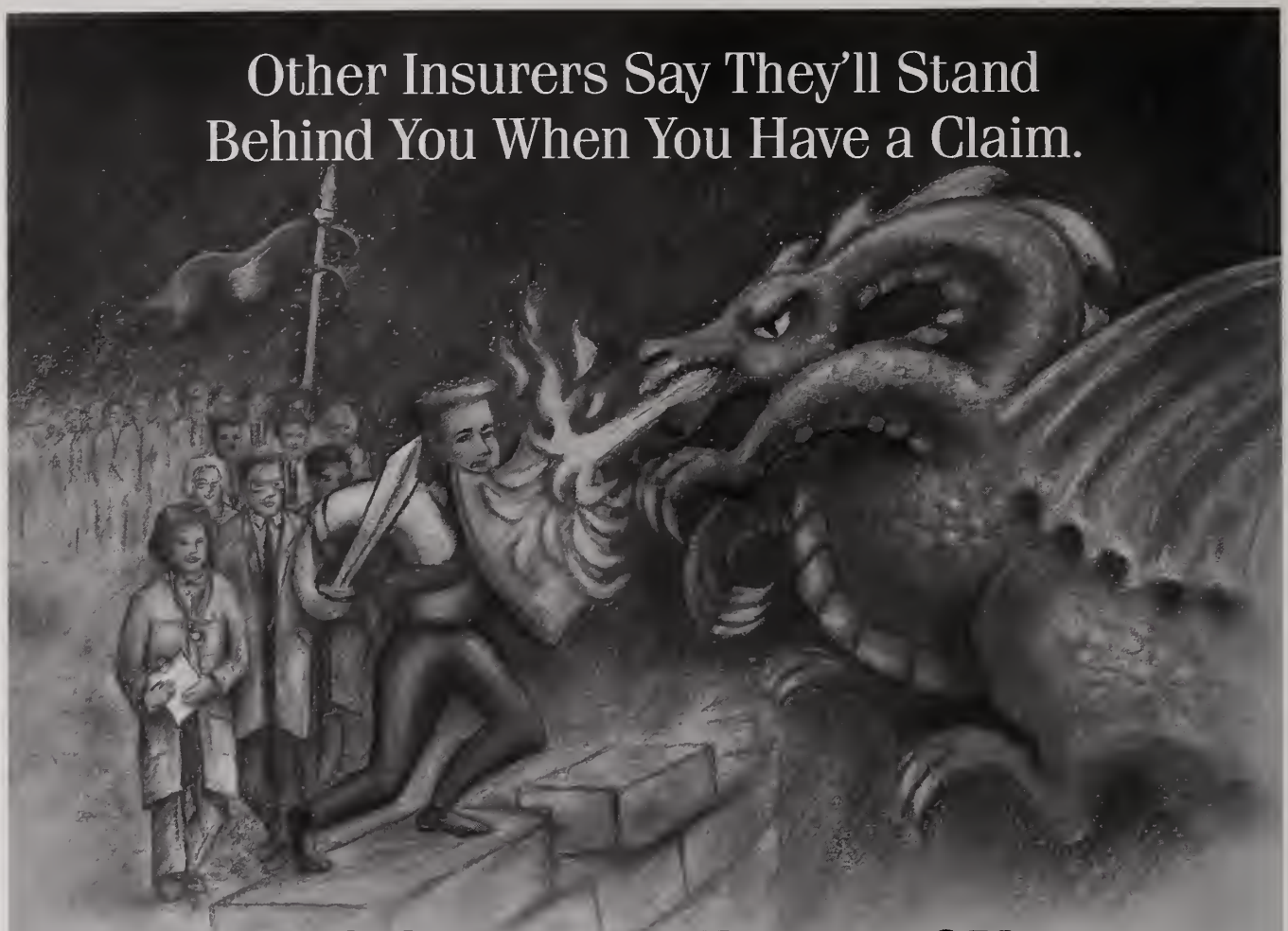
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COVER:
Louisville surgeons discuss the importance of early recognition and diagnosis of melanoma.

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COVER STORY	Diagnosis and Treatment of Cutaneous Melanoma of the Head and Neck (Grand Rounds) *Wayne K. Stadelmann, MD; Kelly McMasters, MD, PhD; Hiram C. Polk, Jr, MD*	46
SCIENTIFIC	Venomous Snake Bite of a Child *Michael W. Simon, MD, PhD*	56
	Primary Care Rounds — "The Middle-Aged Golfer" *Craig C. Davis, MD*	59
MEDICO-LEGAL	PHYSICIANS BEWARE! Dealing With Tax-Exempt Healthcare Organizations Can Be Hazardous to One's Financial Health *James C. Seiffert, Esq*	65
EDITORIAL	I've Had a Good Run! *Milton F. Miller, MD*	63
ASSOCIATION	*Monitoring Medicine*	43
	Journal Editors Honored by House of Delegates	73
	Actions of Reference Committee on Amendments to Constitution & Bylaws — AMA Interim Meeting, December 1997	74
	KMA Board of Trustees December Meeting	75
	News	76
DEPARTMENTS	President's Page	41
	Advertisers' Guide	82
	Alliance Page	70
	Classifieds	81
	Continuing Education	72
	Information for Authors	61
	Letters to the Editor	68

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Crises Intervention



Harry W. Carloss, MD

The publication deadline for this message is early December, after the special session on health insurance and before the beginning of the biennial legislative session. At this time in my hometown of Paducah, Kentucky, it is difficult to concentrate on anything without having your mind wander to the senseless carnage at one of our local high schools. This event directly or indirectly touched almost everyone in our small community. The local hospital emergency room and staff and the community physicians responded admirably, tearfully, as children of our friends, co-workers, and neighbors were brought in for treatment. Everyone did their jobs; no-one was concerned about all of the minor things that preoccupy our lives on a daily basis. The competitive environment amongst ourselves, hospitals, and various insurance plans were forgotten. The immediate threat was addressed in an all encompassing manner.

History teaches us that in a crisis, individuality and differences are sacrificed for a greater common goal. It is easy to pull together in such a threat. However, when the threat is insidious, it is less likely to elicit a similar response. As physicians we have observed radical changes in our healthcare system. We have seen the adoption of a healthcare plan that has dramatically increased the number of uninsured patients in our state. It has disproportionately and adversely affected children. There are national trends affecting patient rights and physician choice. Physicians have been prevented from discussing treatment options. Treatment decisions are being formed on the basis of cost rather than sound medical judgment.

We must recognize that these insidious changes will produce a decrease in quality and quantity of life just as surely as a gunman's bullets. Physicians must act together as we would in an emergency situation. We must influence legislation to improve medical care for the population. We must protect those who cannot speak for themselves or who do not comprehend the results affected by change. We would never think that we were too tired, too busy, or too self concerned to act in a medical emergency. We must also adopt this attribute to insidious political change and profit motivation in healthcare.

Help your lobbyist and legislative quick action committee by being informed. Read the *Communicator* and legislative bulletins. Contact your legislators. You can leave a message for them in Frankfort at 1-800-372-7181.

Harry W. Carloss, MD
KMA Vice President



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NEWS FOR KENTUCKY PHYSICIANS
1998 KENTUCKY GENERAL ASSEMBLY

The following legislation, introduced through January 31, 1998, relates to medical practice and health care.

LEGEND:
Bill Number/Sponsor/Bill Title

SENATE BILLS:

SB 2/128 — Scorsone — KCHIP
Establishes Kentucky Child Health Plan (KCHIP), a preventive health services plan for children up to age 18 in families with income below 250% FPL who are ineligible for Medicaid.
SB 7— Metcalf — DUI
Reduces driving under the influence from 0.10 to 0.08
SB 14/73 — Scorsone — Sale of Non-profit Health Facilities
Requires hearings by Attorney General to assure protection of public investment in non-profit health care facilities.
SB 19/107/110 — Pendleton— Long Term Care Insurance
Excludes premiums paid for LTC Insurance from taxes.
SB 28 — Boswell — Physician Assistants
Allows PAs to prescribe nonscheduled legend drugs
SB 29 — Tori — Abortion
Establishes 24 hour waiting period for abortion procedures.
SB 38 — Seum — Motorcycle Helmets
Permits 21 year olds or older to ride a motorcycle without helmets.
SB 56 — Nunnelley — Prescription Provider tax
Repeals prescription provider tax.
SB 63/90 — Buford — Autism
Mandates health insurance coverage for Autism; $500 monthly limit.
SB 121/124 — Boswell — Partial Term Abortion
Criminalizes performance of partial term abortion.
SB 135 — Herron — Managed Care
Requires managed care entities to provide list of participating providers.
SB 140 — Nelson — Omnibus Health Insurance Reform
Reforms previous (1994-96) health insurance legislation.
SB 145 — Pendleton — Brain Injury Trust Fund
Establishes Traumatic Injury Trust Fund. Program funded by moving vehicle violations and DUI convictions.
SB 146 — Pendleton — Tobacco
Moves jurisdiction for enforcement of violations by minors purchasing tobacco products from the Department of Agriculture to Juvenile Session of District Court.

HOUSE BILLS:

HB 1— Adams — Water Safety
Establishes age limits for individuals operating personal watercraft.
HB 5/408 — Hogancamp — Partial Birth Abortion
Criminalizes performance of partial birth abortion.
HB 27— Bowling — Lethal Injection for Execution
Permits lethal injections. Prohibits physician involvement except to certify death, but only after condemned has been declared dead by another individual.
HB 70 — Crimm — Abortion Facilities
Defines abortion facilities and requires licensure.
HB 85 — Stine — Abortion
Requires 24 hour waiting period for abortions.
HB 106 — P. Clark — Motorcycle Helmets
Permits motorcyclists over 21 to ride motorcycles without helmets.
HB 115 — Coleman — Prescription Drug Abuse
Implements the Attorney General Task Force recommendations.
HB 118 — Wayne — Medicaid
Expands Medicaid coverage to include autism and pervasive developmental disorders.
HB 124 — Mason — Medicaid
Mandates physician participation in Medicaid.
HB 125/255 — Mason — KCHIP
Implements Federal/State financed Kentucky Child Health Insurance Program
HB 128 — Brandstetter —
Charitable Health Provider

Defines charitable health care; permits Cabinet for Health Services to license and regulate various "charitable providers."

HB 131 — Burch — TB tests
Deletes requirement that children have skin TB tests.

HB 156 — Marzian Hepatitis B tests
Requires pregnant women to be tested for hepatitis B.

HB 157/184 — Mason — Long Term Care Insurance
Excludes long term care insurance premiums from state taxes.

HB 158 — P. Clark — Naturopathy
Defines the practice of naturopathy. Permits naturopathist to prescribe, perform minor surgery, and obstetrics.

HB 160 — P. Clark — Acupuncture/Oriental Medicine
Defines the practice of acupuncture and establishes the practice of oriental medicine.

HB 178 — Heleringer — Medicaid
Exempts mentally retarded from Medicaid Managed Care.

HB 187 — Burch — Whistle Blowers
Protects hospital employees when reporting violations.

HB 189 — Marzian — ARNP
Permits RNs to teach, delegate, and supervise health services to nonlicensed school personnel.

HB 190 — Marzian — ARNP
Permits ARNPs to sign school attendance statements.

HB 192 — Ballard — Riders in Open Vehicles
Prohibits children under age 18 from riding in open pickup trucks.

HB 213 — Burch — Medicaid
Prohibits developmental disabled from being placed in Medicaid Managed Care.

HB 214 — Marzian — Abortion
Allows additional persons to give minors consent for abortion.

HB 227— Coleman — Fraud and Abuse
Expands fraud and abuse statutes to subjecting officers, administrators, and trustees to same provisions as providers; refusing to refer when medically necessary; increases penalties and fines; expands lien on providers property who violates laws; increases and expands Attorney General's role in Fraud & Abuse; establishes new categories of "patient abuse" that include "improper training" by facilities.

HB 243 — Alexander — Alternative Medicine
Defines nonconventional or complementary medicine under the Medical Practice Act. Restricts the Board of Medical Licensure from disciplining alternative physician practitioners.

HB 244 — Burch — Health Insurance Reform
Strengthens present provisions adopted under HB 250.

HB 254 — Marzian — Bicycle Helmets
Requires children under age 14 riding bicycles
to wear helmets.

HB 278 — Gray — MSAs
Establishes medical savings accounts.

HB 285 — Coleman — Pronouncement of Death
Permits specially trained paramedics to pronounce death.

HB 292 — Kerr — Defines Human Beings
Declares unborn child in uteros as a human being and person.

HB 293 — Kerr — Prosecution/Unborn in Uteros
Allows prosecution for wrongful death for unborn child in uteros.

HB 299 — Marzian — Brain Injury Trust Fund
Establishes Kentucky Traumatic Brain Injury Trust Fund. Program funded through fines for moving vehicle violations and DUI.

HB 302 — Nunn — Renal Dialysis
Requires renal dialysis facilities to have energy backup resources.

HB 304 — Marzian — Boards and Commissions
Requires all Boards and Commissions to be equally represented by male and female.

HB 315 — Damron/DeWeese — Health Insurance Reform
Health insurance reform; patient protection and provider fairness; requires health insurers to support "uninsurable" either through taxes or to insure equitable numbers; defines "high risk."

HB 322 — Coleman — DUI
Reduces BAC in DUI cases from 0.10 to 0.08.

HB 324 — Lindsay — Non-profit Facilities
Requires Attorney General to hold public hearings and protect public interest when "for profits" purchase non-profit health facilities.

HB 380 — Marzian — Diabetes
Requires health benefit plans to cover diabetes.

HB 381 — Marzian — Tobacco Sales to Minors
Permits local governments to enact more stringent laws to restrict minors' access and purchase of tobacco products.

HB 398 — Crall — Health Insurance
Repeals most health insurance laws enacted in 1994 through HB 250; retains patient protection and provider fairness provisions.

HB 403 — Crimm — Clinical Exercise Physiologists
Licenses CEPs under Board of Medical Licensure.

HB 423 — Scott — Emergency and Disaster Personnel
Grants immunity to voluntary disaster and emergency response teams and personnel when acting in good faith.

NATIONAL LEGISLATION

The following is a letter from KMA President Ken Peters, MD, to the Regional Administrator of HCFA. This letter was sent in response to a HCFA pamphlet recently issued to Medicare beneficiaries regarding fraud and abuse.

Ms Rose Crum-Johnson
Regional Administrator
Health Care Financing Administration
101 Marietta Street
Suite 702
Atlanta, Georgia 30323

Dear Ms Crum-Johnson:

I would like to express the Kentucky Medical Association's concern regarding a recent publication from your office. In the *Medicare Update* for Fall/Winter 1997, the following statement appears twice on the first page: "Despite our efforts, it is estimated that as much as $23 billion was stolen from Medicare." It is becoming commonplace for those in the press and public to use the $23 billion figure when referring to Medicare fraud and it is misleading. I was disappointed to see your agency also using this figure.

A report issued by the Congressional Research Service does not support your contention that $23 billion was **stolen** from Medicare. The report, entitled *Health Care Fraud: A Brief Summary of Law and Federal Anti-Fraud Activities*, states: "A financial audit report issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) in July, 1997, estimated that improper Medicare payments made in FY 1996 totaled $23 billion . . . These improper payments ranged from inadvertent mistakes to outright fraud and abuse. The OIG could **not** quantify what portion of the error rate was attributable to fraud." (emphasis in original)

The charged atmosphere surrounding health care fraud and abuse is troubling and the use of inaccurate statements inflames this atmosphere. Physicians support the investigation and prosecution of anyone who knowingly violates the law. But, the line between what may be classified as fraud and what may be classified as an honest disagreement is not always clear. As physicians, we have struggled with HMOs and managed care regarding the determination of what is "medically necessary" in the treatment of patients. Physicians are in the best position to make this determination and the public seems to agree. The Clinton Administration, Congress, and many states are preparing legislation to allow patients more rights when a health plan disagrees with a physician. Must we now tell our patients we cannot disagree with government officials on matters regarding treatment because of the threat of prosecution? This is becoming a very real concern for physicians.

Unsubstantiated statements from government agencies damage the physician/patient relationship and bring discredit to the agency. I hope you will not add to this politically charged atmosphere by making misleading statements similar to the one in your latest publication and I urge you to print a clarification regarding these facts.

C. Kenneth Peters, MD
President

cc: Kentucky's Congressional Delegation
American Medical Association



Diagnosis and Treatment of Cutaneous Melanoma of the Head and Neck

Wayne K. Stadelmann, MD; Kelly McMasters, MD, PhD; Hiram C. Polk, Jr, MD

There were an estimated 40,300 cases of melanoma in the United States in 1997, of which 7,300 resulted in death.[1] In Kentucky alone in 1996, approximately 630 individuals were diagnosed with melanoma, and 120 died of the disease. Fortunately, there is a growing awareness of the severity of the melanoma epidemic. Through increased public education and screening of suspicious skin lesions by family practitioners and dermatologists, patients with melanoma are being diagnosed at an ever earlier stage, when the chance for cure is the greatest. Additionally, emerging technology has made the treatment of melanoma more specific and less invasive. Public awareness, improved early detection, and new technical advances are particularly important when treating patients with cutaneous head and neck melanoma. In this review, we discuss the importance of early recognition and diagnosis of melanoma, the appropriate work-up, as well as some of the indications for, and details of, emerging technology in the treatment of melanoma, especially as it relates to the head and neck.

Case 1: A 50-year-old man was evaluated by his family physician for a pigmented "mole" on his scalp along the midline near the coronal suture. The lesion had irregular borders, an irregular surface, variegated pigmentation, and was about 7 mm in diameter. The patient had no symptoms, was otherwise healthy, and had no family history of melanoma. On the advice of his physician, a full-thickness, 3-mm punch biopsy was performed in the office using local anesthesia. This revealed a 1.3 mm, Clark level IV, nonulcerated malignant melanoma. The patient was subsequently referred to the University of Louisville's J. Graham Brown Cancer Center for further care.

At the University of Louisville, the patient was found to have no parotid, cervical, or clavicular adenopathy, and had no findings or symptoms suggesting distant metastatic disease. In addition to a complete history and physical examination, the work-up consisted of a chest x-ray and a liver function profile; the results of which were all found to be normal. Because the patient had no adenopathy and no evidence of metastatic disease, no further screening tests were needed. The patient subsequently underwent preoperative lymphatic mapping in the nuclear radiology suite on the morning of his operation. This demonstrated drainage of the primary tumor site to *both* cervical regions directly beneath the sternocleidomastoid muscles. Later that same afternoon, the patient underwent a wide local excision of the primary tumor with 2-cm margins. He also underwent a biopsy of bilateral cervical sentinel lymph nodes through two small incisions (Figs 1 and 2). These nodes were found to be free of tumor. His recovery has been uneventful, and no further treatment has been recommended other than regular follow-up by his family physician and his melanoma surgeon.

This case demonstrates several key issues that will be addressed in this review: melanoma identification, diagnosis and work-up, surgical margins of excision, guidelines for lymph node evaluation, indications for adjuvant therapy, and the need for close postoperative follow-up examinations and ongoing screening for subsequent new primary melanomas.

Diagnosis and Initial Management of Head and Neck Cutaneous Melanoma

It is safe to argue that the greatest single advancement in the treatment of melanoma in the past decade has been greater public awareness of melanoma and the early diagnosis of the disease by primary care physicians and dermatologists. The prognosis of melanoma correlates directly with

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Table 1. Differential Diagnosis of the Pigmented Skin Lesion

Malignant melanoma (nodular, superficial spreading, lentigo maligna, amelanotic, acral lentiginous, desmoplastic)
Dermatofibroma
Melanonychia striata
Subungual hematoma
Pigmented basal cell carcinoma
Lentigines: solar lentigines, lentigo simplex
Melanocytic nevi: junctional, intradermal, compound
Nevus spilus
Blue nevus
Spitz nevus
Dysplastic nevus
Halo nevus
Hemangiomas
Venous lakes
Pyogenic granuloma
Kaposi's sarcoma
Pigmented actinic keratosis
Pigmented Bowen disease
Extramammary Paget disease

Table 2. Worrisome Physical Findings When Evaluating a Skin Lesion

Asymmetry of the overall pattern
Border irregularity
Color variegation especially red, white, and blues
Diameter greater than 6 mm

Table 3. Staging Based on 1992 Joint Committee on Cancer Staging for Cutaneous Melanoma

Stage I:	Tumor less than 1.5 mm in thickness and/or invades the papillary dermis or abuts the papillary reticular-dermal interfaces (Clark level II and III) No lymph node metastases. No systemic involvement.
Stage II:	Tumor greater than 1.5 mm and/or invades the reticular dermis or subcutaneous tissues (Clark level IV and V) and/or satellites within 2 cm of the primary tumor. No lymph node metastases. No systemic involvement.
Stage III:	Any tumor thickness or level of invasion. Lymph node involvement. No systemic metastases.
Stage IV:	Any tumor thickness or level of invasion. Any level of lymph node involvement. Distant metastases present.

tumor thickness. Far more lives are saved by early detection and treatment of melanoma, at a stage in which surgical excision alone is often curative, than are saved by new technology and adjuvant therapy.

The diagnosis of melanoma should be considered whenever a cutaneous lesion is being evaluated as a possible malignancy (Table 1). Worrisome findings on physical examination can be remembered by the acronym "ABCD": *A*symmetry of the overall pattern; *B*order irregularity; variable *C*olor, especially red, white, and blues; and a *D*iameter greater than 6 mm (Table 2). Also worrisome are any changes in existing moles. These lesions should be considered melanoma until histologically proven otherwise. If the suspicious lesion is small, an *excisional* biopsy with a 1- to 2-mm rim of normal-appearing skin should be performed. Larger lesions that cannot be removed without significant disfigurement or ease should undergo an *incisional* biopsy at the thickest part of the lesion. Shave biopsies are less satisfactory than full-thickness biopsies and should be avoided, if possible, because an accurate assessment of the thickness of the melanoma cannot be obtained from the specimen. Tumor thickness is the single most important prognostic factor for survival of Stage I and II melanoma (no evidence of nodal or distant metastases) (Table 3).[2-6] Tumor thickness also determines the subsequent recommended excisional margins at the time of wide local excision and whether or not the regional lymph nodes should be evaluated. Margins of excision for diagnosis may be kept to a minimum. Removal of excess skin from around the primary tumor may potentially alter the local lymphatic drainage patterns. This may decrease the ability to reliably map the regional lymphatics draining the melanoma, thereby decreasing the success of performing a sentinel lymph node (SLN) biopsy.

Patients diagnosed with malignant melanoma should undergo a total body skin examination to rule-out other cutaneous malignancies and also to establish a baseline. This examination can be performed by the patient's family physician or a dermatologist. Suspicious lesions can be located and documented with a photograph for later comparison. Any interval change in the appearance of suspicious lesions, or if symptoms such as pain, itching, bleeding, or nonhealing occur, immediate evaluation with a full-thickness biopsy is warranted.

Once the primary melanoma has been biopsied and diagnosed, many patients as well as the

treating clinicians will become quite anxious about the timing of the subsequent definitive wide local excision and possible nodal staging procedure. The perception is that every minute spent waiting for the next stage of treatment is another minute available for metastases to spread. While this sentiment merits theoretical consideration, clinical trials have failed to show that waiting 3 or more weeks between the biopsy and the definitive wide local excision negatively influences 5-year survival.[7-9] Patients can therefore be reassured that a delay of a few weeks between the biopsy and the definitive excision and nodal basin biopsy/dissection will not adversely influence their survival.

Work-up to Rule Out Distant Metastatic Disease

The staging work-up of melanoma patients continues to be an area that lacks consensus. Until a histologic diagnosis of melanoma is made, further tests such as x-rays, laboratory work, and computerized tomography should not be obtained. These tests are expensive, often have false-positive results that require more tests for clarification, and generate an unnecessary amount of anxiety, stress, and fear.[10] When melanoma is diagnosed, the work-up should consist of a thorough history and physical examination, chest x-ray, and liver function tests. In patients with no clinical signs of advanced disease, computerized tomography is nearly always negative. Only when the chest x-ray, liver function tests, or history and physical examination are suggestive of advanced lymph node involvement and/or distant metastatic disease should more tests be obtained. Generally, the need for further work-up for metastatic disease should be determined by the surgeon who will be treating the primary melanoma.

Status of the Regional Lymph Nodes

Why do we perform lymph node dissections? There are two basic reasons in oncology to evaluate regional lymph nodes: to stage and to cure. The removal of regional nodal metastases is potentially curative. Even patients with clinically positive (palpable) lymph nodes have a significant long-term survival rate (approximately 25%) with lymphadenectomy alone. Patients who have a single positive lymph node have a 10-year survival rate in excess of 40%, and that survival rate may be even higher now that very early microscopic metastases can be identified using sentinel lymph node technology. Certainly there are some data to suggest that elective lymph node dissection may improve survival in some subgroups of patients, especially those who have intermediate-thickness melanomas.[11]

Controversy continues to surround the issue of how best to treat occult regional nodal metastases. There are currently three options used for treating the regional nodal basins in patients with AJCC Stage I and II disease. In addition to wide local excision of the primary tumor based on the tumor thickness, the regional nodal basin can be either followed clinically without further surgical intervention, removed by an elective lymph node dissection, or evaluated by biopsy of the SLNs draining the primary tumor site. Individual treatment options are as follows.

Wide Local Excision and Close Clinical Follow-up, With Therapeutic Lymph Node Dissection for Palpable Recurrence

Proponents of this approach point out that randomized, prospective trials have repeatedly failed to show a convincing survival benefit for melanoma patients who undergo prophylactic removal of the regional lymph nodes or elective lymph node dissection.[12-14] Furthermore, in patients with melanoma primaries that are located in areas with ambiguous nodal drainage patterns, such as over the head and neck and midline trunk, more than one nodal basin may need to be dissected. This significantly increases the potential morbidity for a procedure of questionable benefit. In the head and neck, the lack of convincing data that neck dissection improves survival may influence many surgeons to adopt the "watch and wait" approach. However, those who favor this approach must accept the fact that some patients will have occult microscopic lymph node metastases.

Wide Local Excision and Elective Lymph Node Dissection

Patients with thin melanomas (<1 mm) have a very good chance for cure with local excision alone without elective lymph node dissection. Patients with thick melanomas (>4 mm) are not believed to benefit from elective lymph node dissection, since they have a very high incidence of both regional and distant metastatic disease.[15] Elective lymph node dissection to remove occult nodal metastases has been advocated for the lymphatic basins draining the site of primary tumors that are of intermediate thickness (1 to 4 mm). To



Fig 1 — Blue dye injection (in another patient with an axillary primary) showing the visible uptake of dye in the lymphatics leading to the draining nodal basin.



Fig 2 — Sentinel node localization using the combination technique of blue dye injection and intraoperative radiolymphoscintigraphy. This combined technique is enormously helpful in the head and neck area.



Fig 3 — Sentinel lymph node in situ. In this particular patient, a forehead melanoma was found to have lymphatic drainage to both the parotid and posterior triangle areas.

date, however, there are no definitive studies that demonstrate a clear advantage to performing or not performing an elective lymph node dissection in this population of patients.[11-14] The major problem with performing an elective lymph node dissection is that only about 20% of patients will have nodal metastases. Eighty percent of patients undergoing an elective lymph node dissection will therefore be subjected to the morbidity of an operation which, in retrospect, they did not require. Ideally, only patients who have a high likelihood of having nodal involvement would be offered a full-nodal basin dissection. This is the area in which sentinel node technology may have its greatest impact.

When treating melanoma primaries over the head and neck region, it is particularly difficult to

determine which nodal basin to explore. Unlike extremity tumors that have a relatively predictable pattern of nodal basin drainage, head and neck tumors can drain to basins that would not typically be included in an elective lymph node dissection.[16-20] In one study, the discordance rate between the predicted lymphatic drainage basin and basin(s) identified on the lymphoscintogram was up to 84%. This led to a change in the operative plan (additional nodal basins dissected or contralateral dissections performed) in 62% of patients.[17]

Wide Local Excision With Lymphatic Mapping and Sentinel Lymph Node Biopsy

Lymphatic mapping and SLN biopsy is a relatively new technique that addresses the problems inherent in the first two strategies discussed earlier. The theory behind SLN mapping is that for any area of skin, there is an afferent lymphatic channel that leads to a specific first-draining lymph node, the sentinel node. The sentinel node, therefore, is the first node to which the melanoma will spread. Melanoma nodal metastases are believed to progress in an orderly and nonrandom fashion. The SLN therefore accurately reflects the status of the lymph nodes in that nodal basin.[21] The likelihood that the SLN is negative while another, non-sentinel node in the same nodal basin is positive (a "skip" metastasis) is rare, occurring in less than 1% of SLNs removed. Sentinel lymph node biopsies are particularly useful for melanomas located in ambiguous lymphatic drainage areas (eg, head and neck, trunk) and where multiple SLNs are the rule rather than the exception. Failure to identify and subsequently remove all of the SLNs represents an inadequate nodal staging procedure and will potentially place the patient at risk for higher recurrence rates.[22]

When the SLN is positive for tumor, the patient is considered for adjuvant therapy, and regional lymph node dissection is strongly advised to remove any potential residual melanoma. When the SLN is negative, the lymphatic basin is observed for the development of clinical nodal involvement. *Sentinel lymph node biopsy should not be confused with a therapeutic procedure. The SLN biopsy is a diagnostic procedure designed to determine the presence of nodal metastases so that a full lymph node basin dissection can be performed and appropriate adjuvant therapy instituted.*

Determining which patients should be offered SLN analysis is based on the probability of developing regional nodal metastases. Generally, patients with a melanoma less than 1-mm thick are considered to be at low risk for nodal metastases. Statistically, SLN mapping would be of very limited value in this population. With melanomas thicker than or equal to 1 mm, the risk of developing regional metastases is sufficiently high enough to justify the procedure.[23] There does not appear to be an upper limit in tumor thickness above which SLN biopsies are no longer indicated. Regardless of the primary tumor thickness, as long as there is no palpable adenopathy or evidence of distant metastatic disease, SLN evaluation is potentially beneficial.

Patients with clinically palpable regional adenopathy should undergo a fine needle aspiration of the nodes to confirm the clinical diagnosis. If the fine needle aspiration is positive, a full-nodal basin dissection should be performed. In addition to providing important data regarding future survival, nodal basin dissection may prove to be curative in up to 20% of patients.[24,25] Palpable adenopathy in the head and neck is best addressed at an early stage to avoid the potential wound healing problems and challenges associated with large resections for uncontrolled regional disease.

Sentinel lymph node technology allows nodes to be removed from any area of the head and neck. Although it is richly invested with lymphatic tissue, the parotid gland is not a lymphatic organ. There is no oncologic or physiologic reason to remove the entire gland. Ninety percent of the lymph nodes in the parotid gland are superficial to the facial nerve, minimizing the risk of facial nerve damage during the biopsy procedure.[26] Routine superficial parotidectomies are no longer indicated for melanoma staging. To date, no definitive studies have proven that elective lymph node dissection improves survival; however, it is known that elective lymph node dissection involving the parotid gland is positive for metastatic disease in only 5% of patients.[27] Superficial parotidectomy is also a potentially morbid procedure with a high complication rate.[27] Recently, a series of 23 patients treated with parotid SLN biopsies has been reported, revealing a high rate of successful node retrieval and a low incidence of complications.[28]

Although SLN technology has great potential promise, randomized prospective trials with adequate follow up remain forthcoming. Until these studies are published and demonstrate comparable disease-free and 5-year survival statistics, this new technology must continue to be considered investigational.

Intraoperative Treatment of the Primary Tumor

Historically, the margins of excision for malignant melanoma were excessively wide.[29] Prospective, randomized clinical trials have shown that narrower margins of excision do not correlate with decreased 5-year survival.[2,30-32] Currently, the margins of wide local excision are determined by the thickness of the primary tumor (Table 4). These margins should be adhered to as closely as possible when dealing with melanomas located over the head and neck. In situ lesions should have a 0.5-cm margin,[2] tumors less than 1 mm should have a 1-cm margin,[30] and tumors greater than 1 mm but less than 4 mm in thickness should have an excision with margins proportionate to thickness.[31,32] Data for tumors greater than 4-mm thick is lacking, however, it is generally believed that these tumors should be excised with *at least* a 2-cm margin of uninvolved skin. When treating melanomas located near critical anatomic areas such as the eyelids, nose, and other aesthetic areas over the head and neck, using the recommended margins may result in deformity and/or loss of function. Generally, smaller margins are used in such circumstances. If narrower-than-recommended margins are to be used, the patient needs to be made aware that a trade off is being made between aesthetics and function and local recurrence rates. The decision to use narrower margins should be clearly documented in the patient's chart.

The depth of tumor excision should include the full thickness of the skin and some underlying subcutaneous tissue preserving the underlying fascia, perichondrium, and periosteum.[33] Local tissue flap and free-tissue reconstruction were discouraged in the past because of the concern that tumor recurrences would be concealed, delaying the detection and worsening the outcome.[34] Clinically, flap reconstruction has not been shown to worsen the disease-free survival rates or the local recurrence rate.[35]

Table 4. Recommended Margins of Excision of the Primary Melanoma

Thickness (mm)	Margin (cm)
In situ	0.5
<1	1
1-4	2*
>4	At least 2†

*Narrower margins may be taken on the face in critical aesthetic and functional areas.
†No studies available that specifically address margins in tumors thicker than 4 mm.

Significance of Lymph Node Status

The presence of lymph node metastases in patients with melanoma reduces the 5-year survival by 40%.[36] Although many other factors relating to the primary tumor may be taken into consideration in determining prognosis, these are all relatively unimportant when nodal metastases are considered.[37] As is true with most solid tumors, one of the most powerful prognostic indicators of survival in melanoma is the number of lymph nodes involved with metastatic tumor. Patients with one positive node fare the best, with 40% alive at 10 years, whereas those with two to four nodes have an intermediate 10-year survival of 18%. Patients with more than 5 nodes have the worst 10-year survival rate at 9%.[37] More importantly, the presence of nodal metastases has become a critical piece of information for determining future adjuvant therapy. This is believed to be especially true if the tumor burden is small, such as when micrometastases are identified by using very sensitive assays to evaluate lymph nodes. The combination of SLN technology and highly sensitive assays for evaluating lymph nodes has made it possible to stage melanoma in patients quickly, accurately, and with a minimal amount of morbidity.

Adjuvant Therapy

Until recently, little could be offered other than palliative therapy to the patient who had regional metastatic disease. The poor prognosis usually reflected the late stage at which the diagnosis was made when multiple regional nodes were involved. Adjuvant forms of therapy have also been relatively ineffective. Recently, the results of the Eastern Cooperative Oncology Group Trial # 1684 evaluating the efficacy of interferon alfa 2b were published.[38] This prospective trial randomized high-risk melanoma patients (most with nodal metastases) into receiving either 1 year of high-dose interferon alfa 2b or observation. Interferon alfa 2b was shown to be effective in prolonging relapse-free survival by 11% and overall 5-year survival by 9% for patients with nodal metastases. This drug is now FDA-approved for use as adjuvant therapy in melanoma patients with a high risk of relapse.

Interferon alfa 2b therapy, however, may be associated with severe potential side effects. The recommended drug administration protocol delivers interferon alfa 2b at doses near the maximal tolerated dose, making it difficult for many patients to complete a year's worth of therapy. The side effects, which include flu-like symptoms (fever, myalgia, headache, etc), depression, anorexia, and fatigue, can be debilitating. Therefore, it would be best to determine which subgroups of patients would benefit most from interferon alfa 2b, and treat only those who may potentially gain from this form of therapy. Because most of the patients in the Eastern Cooperative Oncology Group Trial[38] had advanced disease (palpable or recurrent lymph node metastases), it is important to verify these results in more favorable groups of patients. A particularly interesting group are those with a single microscopic lymph node metastasis identified by lymphatic mapping and sentinel lymph node biopsy. Once again, the importance of early detection and diagnosis on the part of the primary physician cannot be overemphasized.

Radiotherapy may play a role as an adjuvant to therapeutic node dissection. Local control in excess of 85% has been reported when radiotherapy was used as an adjunct to node dissection in pathologically node-positive patients and in patients with extra-nodal disease.[39] Other studies confirm these favorable results.[40] Our practice is to recommend radiotherapy when nodal metastases are numerous.

Patients with Stage IV disease (distant metastases) have little chance for cure.[41] Management should involve a careful examination to determine whether chemotherapy, radiation therapy, and surgical intervention may play a role in preserving the quality of life. The goal in Stage IV disease should be to reduce the incidence of complications and pain. In the asymptomatic patient with end-stage disease, no intervention may be the best approach.

Follow Up

Most melanoma recurrences occur within 3 years after excision. Postoperatively, patients are asked to return at decreasingly frequent intervals to undergo a screening history and physical examination. Chest x-rays and liver function testing, when indicated, are performed annually. If these screening measures disclose signs or symptoms of possible systemic disease, further tests are performed, as indicated. Patients and their families are also informed about how to identify signs and symptoms of melanoma recurrence, especially local recurrences. In one study, 90% of patients with recurrent disease had a history of symptoms such as local nodularity, satellites, adenopathy, chronic cough, headaches, bone pain, gastrointestinal disturbances, etc.[42] Close follow up with a dermatologist for whole body skin examinations is also wise, since many of these patients will develop future cutaneous malignancies. The risk of developing a second and a third primary melanoma is as high as 3% to 7%.[43]

Ongoing Research

The Sunbelt Melanoma Trial is a randomized, prospective study involving almost 1,400 patients at 60 different institutions from around the country. The study was developed and initiated at the University of Louisville, Department of Surgery. It is the only major multi-institutional trial of lymphatic mapping and sentinel lymph node biopsy for melanoma (ongoing or planned) in the world. The goal of the study is to determine whether interferon alfa 2b therapy improves survival in patients with very early nodal metastases detected by lymphatic mapping and sentinel lymph node biopsy. The study incorporates sensitive PCR assays of sentinel nodes and of peripheral blood cells to detect circulating melanoma cells. Patients with melanomas thicker than 1 mm, and who have no clinical adenopathy or distant metastases, are potentially eligible to be enrolled in this study.*

Conclusion

As the melanoma epidemic progresses, more and more primary care physicians and dermatologists will be asked to evaluate and work-up suspicious skin lesions. It cannot be overemphasized that early detection remains the best method to improve survival. Many thin melanomas are cured with simple excision without the need to do further expensive or painful tests or biopsies. In patients with localized melanoma greater than 1 mm in thickness and without clinical nodal involvement, controversy continues to surround the issue of whether or not, and how to, evaluate the nodal basin for micrometastatic disease. Determining which nodal basin is at risk is often difficult, if not impossible, as is the case in the head and neck melanoma. The SLN technique, although still investigational, offers great promise in this area. This is proving to be highly reliable,

accurate, relatively easy to perform, with minimal associated risk and morbidity. With fewer lymph nodes removed, greater care and more specific and sensitive studies can be performed on those nodes, such as immunohistochemical stains and the newly developed and highly sensitive RT-PCR assay. Clinical trials pioneered at The University of Louisville are now in progress, evaluating the usefulness of RT-PCR technology and its role in determining who will benefit from interferon alfa 2b therapy.

We conclude that factors such as increased public awareness; prompt recognition, diagnosis, and referral for surgical excision; newer methods to obtain and evaluate regional lymph nodes; and more effective adjuvant therapy for patients at high risk, are the primary reasons why patients with melanoma are no longer in a hopeless position.

*The Sunbelt Melanoma Trial is supported by the James Graham Brown Cancer Center, the Center for Advanced Surgical Technologies (CAST) of Norton Hospital, and the Norton Hospital Cancer Treatment Center. For more information, contact Vicki Viar, RN, MSN, at 502-629-3381.

References

1. Parker SL, Tong T, Bolden S, Wingo PA. Cancer Statistics, 1996. *CA Cancer J Clin.* 1996;46:3-4.
2. Evans GRD, Manson PN. A variation in the appearance of melanoma-in-situ (Clark's level I malignant melanoma). *Plast Reconstr Surg.* 1994;94:513-517.
3. Meyskens FL Jr, Berdeaux DH, Parks B, Tong T, Loescher L, Moon TE. Cutaneous malignant melanoma (Arizona Cancer Center experience). I. National history and prognostic factors influencing survival in patients with stage I disease. *Cancer.* 1988;62:1207-1214.
4. Schuchter L, Schultz DJ, Synnestvedt M, et al. A prognostic model for predicting 10-year survival in patients with primary melanoma. *Ann Intern Med.* 1996;125:369-375.
5. Balch CM, Soon SJ, Murad TM, Ingalls AL, Maddox WA. A multifactorial analysis of melanoma. II. Prognostic factors in patients with stage I (localized) melanoma. *Surgery.* 1979; 86:343-351.
6. Drzewiecki KT, Andersen PK. Survival with malignant melanoma: a regression analysis of prognostic factors. *Cancer.* 1982;49:2414-2419.
7. Eldh J. Excisional biopsy and delayed wide excision versus primary wide excision of malignant melanoma. *Scand J Plast Reconstr Surg.* 1979;13:341-345.
8. Landthaler M, Braun-Falco O, Leitl A, Konz B, Holzel D. Excisional biopsy as the first therapeutic procedure versus primary wide excision of malignant melanoma. *Cancer.* 1989; 64:1612-1616.
9. Lederman JS, Sober AJ. Does wide excision as the initial diagnostic procedure improve prognosis in patients with cutaneous melanoma? *J Dermatol Surg Oncol.* 1986;12:697-699.
10. Buzaid AC, Ross MI, Soong SJ. Classification and staging. In: Balch CM, et al, eds. *Cutaneous Melanoma;* 3rd ed. St. Louis: Quality Medical Publishing, 1998:37-50.
11. Balch CM, Soong SJ, Bartolucci AA, et al. Efficacy of an elective regional lymph node dissection of 1 to 4 mm thick melanomas for patients 60 years of age and younger. *Ann Surg.* 1996;224:255-266.
12. Veronesi U, Adamus J, Bandiera DC, et al. Inefficacy of immediate node dissection in stage I melanoma of the limbs. *N Engl J Med.* 1977;297:627-630.
13. Sim FH, Taylor WF, Ivins JC, Prichard DJ, Soule EH. A prospective randomized study of the efficacy of routine elective lymphadenectomy in management of malignant melanoma: preliminary results. *Cancer.* 1978;41:948-956.
14. Coates AS, Ingvar CI, Petersen-Schaefer K, et al. Elective lymph node dissection in patients with primary melanoma of the trunk and limbs treated at the Sydney Melanoma Unit from 1960 to 1991. *J Am Coll Surg.* 1995;180:402-409.
15. Crowley NJ, Seigler HF. The role of elective lymph node dissection in the management of patients with thick cutaneous melanoma. *Cancer.* 1990;66:2522-2527.
16. Norman J, Cruse CW, Espinosa C, et al. Redefinition of cutaneous lymphatic drainage with the use of lymphoscintigraphy for malignant melanoma. *Am J Surg.* 1991;162:432-437.
17. Wells KE, Cruse CW, Daniels S, Berman C, Norman J, Reintgen D. The use of lymphoscintigraphy in melanoma of the head and neck. *Plast Reconstr Surg.* 1994;93:757-761.
18. Berman CG, Norman J, Cruse CW, Reintgen DS, Clark RA. Lymphoscintigraphy in malignant melanoma. *Ann Plast Surg.* 1992;28:29-32.
19. Feind CR, Cole RM. Contralateral spread of head and neck cancer. *Am J Surg.* 1969;118:660-665.
20. Wanebo HJ, Harpole D, Teates CD. Radionuclide lymphoscintigraphy with technetium 99m antimony sulfide colloid to identify lymphatic drainage of cutaneous melanoma at ambiguous sites in the head and neck and trunk. *Cancer.* 1985;55:1403-1413.
21. Reintgen DS, Cruse CW, Wells KE, et al. The orderly progression of melanoma nodal metastases. *Ann Surg.* 1994; 220:759-767.
22. O'Brien CJ, Uren RF, Thompson JF, et al. Prediction of potential metastatic sites in cutaneous head and neck melanoma using lymphoscintigraphy. *Am J Surg.* 1995;170:461-466.
23. Singluff C, Stidham KR, Ricci WM, Stanley WE, Seigler HF. Surgical management of regional lymph nodes in patients with melanoma. *Ann Surg.* 1994;219:120-130.
24. Buzaid AC, Tinoco LA, Jendiroba D, et al. Prognostic value of size of lymph node metastases in patients with cutaneous melanoma. *J Clin Oncol.* 1995;13:2361-2368.
25. Reintgen DS. Melanoma nodal metastases. *Surg Oncol Clin N Am.* 1996;5:105-120.
26. McKean ME, Lee K, McGregor IA. The distribution of lymph nodes in and around the parotid gland: an anatomical study. *Br J Surg.* 1985;38:1-5.
27. O'Brien CJ, Petersen-Schaefer K, Papadopoulos T, Malka V. Evaluation of 107 therapeutic and elective parotidectomies for cutaneous melanoma. *Am J Surg.* 1994;168:400-403.
28. Wells KE, Stadelmann WK, Rapaport DP, Hamlin R, Cruse CW, Reintgen DS. Parotid gland sentinel lymphadenectomy in malignant melanoma. Fourth World Conference on Melanoma. Sydney, Australia, June 12, 1997.
29. Handly WS. The pathology of melanotic growths in relation to their treatment. *Lancet.* 1907;1:927,996.
30. Veronesi U, Cascinelli N. Narrow excision (1-cm margin). *Arch Surg.* 1991;126:438-441.

31. Balch CM, Urist MM, Karakousis CP, et al. Efficacy of 2-cm surgical margins for intermediate-thickness melanomas (1 to 4 mm). *Ann Surg.* 1993;218:262-269.
32. Karakousis C, Balch CM, Urist MM, Ross MM, Smith TJ, Bartalucci AA. Local recurrence in malignant melanoma: long term results of the multiinstitutional randomized surgical trial. *Ann Surg Oncol.* 1996;3:446-452.
33. Kenady DE, Brown BW, McBride CM. Excision of underlying fascia with a primary malignant melanoma: effect on recurrence and survival rates. *Surgery.* 1982;92:615-618.
34. Polk HC Jr. Malignant melanoma: current perspectives with emphasis upon treatment according to prognosis. *J Ky Med Assoc.* 1978;76:593-598.
35. Lent WM, Ariyan S. Flap reconstruction following wide local excision for primary malignant melanoma of the head and neck region. *Ann Plast Surg.* 1994;33:23-27.
36. Reintgen DS, Albertini J, Miliotes G, et al. The accurate staging and modern day treatment of malignant melanoma. *Cancer Research Therapy Control.* 1995;4:183-197.
37. Stadelmann WK, Rapaport DP, Soong SJ, Reintgen DS, Balch CM. Prognostic, clinical, and pathologic features. In: Balch CM, et al, eds. *Cutaneous Melanoma;* 3rd ed. St. Louis: Quality Medical Publishing, 1998:11-35.
38. Kirkwood JM, Strawderman MH, Ernstoff MS, Smith TJ, Borden EC, Blum RH. Interferon alfa-2b adjuvant therapy of high-risk resected cutaneous melanoma: the Eastern Cooperative Oncology Group Trial EST 1684. *J Clin Oncol.* 1996;14:7-17.
39. Ang KK, Byers RM, Peters LJ, et al. Regional radiotherapy as adjuvant treatment for head and neck malignant melanoma. *Arch Otolaryngol Head Neck Surg.* 1990;116:169-172.
40. Trotti A, Peters LJ. The role of radiotherapy in the primary management of cutaneous melanoma. *Ann Plast Surg.* 1992;28:39-44.
41. Barth A, Wanek LA, Morton DL. Prognostic factors in 1,512 melanoma patients with distant metastases. *J Am Coll Surg.* 1995;181:193-201.
42. Schumate CR, Urist MM, Maddox WA. Melanoma recurrence surveillance: patient or physician based? *Ann Surg.* 1995; 221:566-571.
43. Scheibner A, Milton GW, McCarthy WH, Norlund JJ, Pearson LJ. Multiple primary melanomas: a review of 90 cases. *Australas J Dermatol.* 1982;23:1-8.

Venomous Snake Bite of a Child

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Venomous snake bites account for 9 to 15 deaths yearly. This is a low number considering that approximately 8,000 venomous snake bites occur each year. These deaths may be prevented by proper and timely medical treatment.

It is estimated that 8,000 venomous snake bites occur each year in the United States.[1] Approximately 99% of these bites are from the pit vipers, including: prairie rattlesnake, cotton-mouth or water moccasin, and copperhead.[2] About 1% of venomous snake bites are from the coral snake.

Venomous snake bites result in 9 to 15 deaths per year.[1] These deaths occur in children and adults that are untreated or mismanaged. Children are the victims of 50% of all venomous snake bites,[3] most often involving children 1 to 9 years of age.[1] They are unaware of the hazard and are most likely to pick up a snake. This article reports a case of venomous snake bite in a child and reviews current recommendations for medical management.

Case History

A 5-year-old white male in good health was attending a camp for diabetic children where his mother serves as a nurse. During an evening he stepped from a van onto a grassy area in his bare feet onto a snake. The snake struck him on the right foot. He was taken to a center for emergency care and admitted for observation and treatment of the snake bite.



Figs 1-2

The bite was thought to be that of a copperhead measuring 1 inch width between the fang bite. The complete blood count, coagulation studies, and blood chemistries were normal. The bite did not require antivenin administration. The child was treated conservatively with elevation and close observation over the next several days. No additional changes occurred. Repeat coagulation studies, complete blood count, and blood chemistries were normal.

He was discharged home on Cefalexin and instructed to continue conservative care. The child did well over the following 5 days. Then he developed progressive swelling of his right foot and calf. The day prior to admission he developed a low grade fever that began spiking as high as 40.5 C.

Examination showed a swollen right foot with 2 fang strike marks 1 inch in distance separation (Figs 1,2). There was a poorly defined surrounding red zone. No necrosis was present. The bite area was tender on palpation. Good capillary refill was noted in the nail beds. The right ankle was noted to be warm compared to the left. The right calf was tender but not tense on palpation.

He was admitted to the hospital for treatment of secondary cellulitis. The child was placed on intravenous fluids and intravenous nafcillin 150mg/kg/day divided into 4 doses. He was also started on Gentamycin 7.5mg/kg/day divided into 3 doses. The area was elevated and warm compresses were applied. The child was given Advil and Tylenol for fever and discomfort control. Admission laboratory studies had a white blood cell count of 10,000, HCT was 35%, with 66% neutrophils, 5% bands, 15% lymphocytes, 9% monocytes, and 5% basophils. Westergren sedimentation rate was 42 with a normal of 1 to 10. Other blood chemistries were normal. A blood culture was collected.

X-rays of the right foot showed dorsal soft tissue swelling. No fracture, dislocation, or periosteal reaction was noted by this procedure. A bone scan was obtained and showed abnormal uptake of activity in the right leg, ankle, and foot through all three phases. The increased activity persisted and was still observed in delayed images 5½ hours after the injection. The findings were consistent with the child having periostitis. The blood culture was sterile. The child was discharged to home and

received 4 additional weeks of intravenous ceftriaxone 1 gram a day through a PICC line. Recovery proved uneventful and he continues to do well at follow-up.

Discussion

First aid measures are the same for all venomous snake bite victims.[1,2] A rescuer should splint or immobilize the bitten extremity in a functional position below the level of the heart and remove all constricting items. Keep the individual calm and inactive to minimize circulation. Do not apply ice, offer alcoholic beverages, or cut the bite area. Do not apply a tourniquet. Most snake bites occur within a short distance from emergency medical care, and the vast majority of bites are not immediately life threatening.[4]

The individual is transported as soon as safely possible to an emergency center. Have a description and size or, if possible, take the dead snake to the hospital for identification. Carefully collect it with a stick and place it in a bag. Dead snakes can bite by reflex.[2] If transported by ambulance an intravenous line should be started.

Each bite requires individual treatment with consideration of envenomation. Snake bite venom is composed of a mixture of toxins, including hemotoxins, cardiotoxins, and neurotoxins.[2] Pit viper venom is more likely to produce local tissue destruction through components that digest tissue. Cardiotoxic and neurotoxic effects occur with large quantities of envenomation. The toxic effects of coral snake venom are neurotoxic and cardiotoxic.[2]

Bites of smaller snakes are usually less serious, delivering less venom and less injury from the fangs. Copperheads produce mild venom and do not threaten the life of a healthy adult. However, children may react more violently to all venomous snake bites and require immediate assessment and intensive therapy.[5]

Death from venomous snake bites is a result of either delay in starting antivenin, or use of inadequate amounts of antivenin. However, before antivenin is administered, information needs to be known about the snake bite and its severity graded. It is important to determine if a snake bite actually occurred, what type of snake was involved, is it poisonous, and did envenomation occur.[2] Abrasions can be produced from a number of sources in the wild and be confused for a snake bite. Surprisingly for 20% of all poisonous snake bites no venom is injected.[2,4] An additional 15% to 40% of snake bites are trivial and do not need antivenin.[1,2] If antivenin is used correctly and in a timely way in the other 50%, morbidity and mortality could be significantly reduced.

Except for the coral snake, mojave rattlesnake, and exotic snakes, administration of antivenin is determined by grading the severity of the venomous snake bite[2]: (A) No envenomation: Fang or teeth marks are present. Sixty minutes after the bite, no swelling and no discoloration have occurred and there is minimal pain. (B) Minimal envenomation: Sixty minutes or more after the bite, possible discoloration, minimal swelling, and pain are present but do not increase in their severity. (C) Mild envenomation: Sixty minutes after the bite, ecchymosis, limb swelling with possible paresthesias, and systemic signs are present. Lab values are abnormal (CBC, platelet count, prothrombin time, partial thromboplastin time, renal function, electrolytes, fibrinogen, fibrinogen split products, sedimentation rate). Symptoms may progressively worsen over a few hours to manifestations of a moderate bite. (D) Moderate envenomation: Within thirty minutes after the bite, edema, ecchymosis, local cyanosis or paresthesia, weakness, nausea, or other systemic signs may develop. Lab values are abnormal. (E) Severe envenomation: The individual is ill. Signs and symptoms rapidly develop. Hypovolemic shock may be present. Coma may occur quickly if venom is injected intravenously.

Mild and minimal envenomation are treated by elevation of the extremity and close observation with monitoring every 4 hours.[2] This is important because symptoms may evolve over several hours following a bite. Antivenin is given intravenously for moderate and severe envenomation.[1,2,7] In the US the same antivenin is used for all snake bites except for the coral snake.[1] Antivenin neutralizes venom, blocking tissue damage and necrosis. Children may need more antivenin than adults because they have a lower resistance and are more susceptible to the toxic effects of venom.[1] Antivenin may be used to speed recovery and reduce pain and swelling.[2]

Antivenin is made from horse serum. Individuals may have an allergic reaction to antivenin. A skin test should be run to horse serum before antivenin is given.[7] A test kit is supplied with the antivenin. An allergic reaction would consist of erythema, hives or itching.[5] It may be followed by severe laryngospasm, bronchospasm, bradycardia, hypotension, unconsciousness, and even death.[7]

The occurrence of reactions may be sub-

stantially reduced by administering 1mg diphenhydramine per kg body weight 15 minutes before antivenin. Administering diluted antivenin at a slow rate or giving antivenin and diphenhydramine simultaneously also reduces the reaction rate.[7] If an allergic reaction occurs, stop the infusion immediately. It may be controlled with intravenous diphenhydramine and epinephrine. If a positive test skin reaction occurs, the physician must weigh if the patient will survive and not experience significant tissue damage without antivenin.[1,7] If the skin test is negative after 10 minutes, administer antivenin. It is best to have intravenous access in two different extremities, one for antivenin and the second for other products or medicine.

The starting dosage of antivenin is based on the severity of envenomation, with weight considered.[7,8] The first doses of antivenin for a child more than 100 pounds with minimal envenomation is 5 vials; moderate envenomation give 10 vials, and for severe 15 vials. Children less than 100 pounds should be given a 50% larger dose. A child bitten by the mojave rattlesnake should receive an initial dose of 10 vials of antivenin.

To reduce the occurrence of allergic reactions, the antivenin is diluted 1:4 with 0.5 normal saline. It is infused at a slow rate of 1.5ml a minute. The child is carefully observed and if no reaction occurs in 10 to 15 minutes the infusion rate is increased. The goal is to complete the infusion in 2 to 6 hours.[1,7]

If tolerated, the dose of antivenin is repeated every 2 hours until the progression of swelling has ended and all paresthesias and muscle fasciculations have ceased. The total dose required to neutralize the toxin and its effects is determined by a child's clinical response.[7]

Coral snake bites are treated differently than pit vipers. Coral snakes bite and chew, working their teeth into the skin. If they are pulled off quickly, envenomation may not occur. Venom may produce pain, paresthesias, nausea, vomiting, muscle tenderness, weakness, fasciculations, dizziness, euphoria, dyspnea, diaphoresis, confusion, diplopia and hypotension.[2] Systemic signs may be delayed for several hours and then progress. Abnormal reflexes and general paralysis indicate evolving toxin effect. Death, if it occurs, would be within 24 hours.[4] If the history indicates a coral snake bite has occurred and it has broken the skin, antivenin should be given. However, check with the regional poison control center first. The antivenin is not effective for the Arizona coral snake and is not used for this snake bite.

Coral snake antivenin is not as effective if given after symptoms develop. Early administration may prevent potentially fatal respiratory collapse from developing.[1,2,4] If treatment is delayed for individuals presenting with systemic symptoms of coral snake bite, antivenin and aggressive treatment are required with early intubation.[2] These individuals should be observed for at least 12 hours.

Children who receive antivenin for a venomous snake bite should be carefully monitored in either the emergency room or intensive care unit. Appropriate treatment should be started for complications such as anemia from hemolysis and coagulopathy and hypotension associated with decreased blood volume.

Fresh frozen plasma, plasma expanders, or fresh whole blood may be needed for these disorders.[1] Because of the nature of the venom injury crystalloid solutions do not correct shock from venomous snake bites. Vasopressor drugs should not be used until the intravascular fluid volume has been replaced.[7] Give oxygen if respiratory distress occurs. Codeine, meperidine, or morphine may be needed for pain control.[1]

Abnormal lab values should be monitored until normal. Wound care for bites is the same as for second degree burns. If blebs or bullae develop in the edematous area, surgical debridement is performed after the third day when the risk of significant bleeding is reduced. This area also would then be treated similarly to a second degree burn.[7]

Tetanus prophylaxis and immune status need to be considered. Corticosteroids should be given if serum sickness develops.[7] Prednisone (1mg/kg/day) is given until the pruritus and urticaria have been resolved for 24 hours. Then the dose of steroid is tapered over 72 hours.

References

1. Russell FE. When a snake strikes. *Emerg Med.* 1990;22:21-43.
2. Lichtenhan JB. Emergency management of poisonous snakebites. *Phys Sport Med.* 1995;23:72-88.
3. Parrish AM, Diekroeger MS, Hall HK. Counting California's snakebites. *Calif Med.* 1964;101:352-357.
4. Kunkel DB. Treating snakebites sensibly. *Emerg Med.* 1991;23:161-171.
5. Snyder CC, Knowles RP. Snakebites. Guidelines for practical management. *Postgrad Med.* 1988;83:52-75.
6. Hardy DL. Fatal rattlesnake envenomation in Arizona: 1969-1984. *Clin Toxicol.* 1986;24:1-10.
7. Wingert WA, Chan L. Rattlesnake bites in Southern California and rationale for recommended treatment. *West J Med.* 1988;148:37-44.
8. Parrish HM, Goldner JC, Silberg SL. Comparison between snakebites in children and adults. *Pediatrics.* 1965;36:251-256.

Primary Care Rounds

"The Middle-Aged Golfer"

Craig C. Davis, MD

A 56-year-old white male comes to your office in the summer after a particularly hot and humid week. The patient describes the following events in his own words. He was on the third hole and had just hit a 250 yard tee shot down the center of the fairway. After teeing off, he climbed into his electric golf cart and rode to his ball down the fairway. Just after climbing out of the cart he felt dizzy. The next event he could remember was waking up on the grass beside the cart. Please answer the questions below.

1. What is the final common pathophysiologic mechanism for all causes of syncope?
2. The most important diagnostic test at this time is to obtain a more complete history. What other questions would you ask your patient and why?
3. What specific areas of the physical examination would you want to assess?
4. Would you order any simple in-office ancillary tests?
5. How would you decide what further diagnostic tests to order and whether or not to admit the patient?
6. What would you tell this patient regarding the operation of an automobile?

Discussion and Answers

1. The final common pathophysiology of syncope is a reduction in cerebral blood flow below a level to sustain consciousness. This can be caused by:
   1. Arrhythmias — fast or slow
   2. Vasomotor mechanisms
      — vasodepressor or vasovagal
      — orthostatic
      — situational: micturition, cough, defecation, swallow
      — carotid hypersensitivity
   3. Severe flow obstruction including advanced pulmonary hypertension, PE, AS, HOCM, intracardiac tumor
   4. Cerebrovascular disease

   Cerebrovascular disease is a rare cause of syncope. I frequently see this considered and searched for near the top of the list on the inpatient service. Routine TIAs and CVAs are not associated with syncope unless the vertebrobasilar system and brainstem are involved or there is massive bihemispheric ischemia. Occasionally subclavian steal syndrome can be associated with syncope. Carotid duplex scanning and CTS/MRIs of the head are therefore rarely indicated in the work-up of syncope.

   The specific causes of syncope vary from study to study.

   This is expected since the causes of syncope in a population will vary depending on:
   (1) The age of the population. For example, younger populations — more vasodepressor cases, older populations — more cardiac cases. Outpatient population — more cardiac, orthostatic cases.
   (2) The source of the cases. For example, CCU population — more orthostatic, situational, vasodepressor cases.
   (3) How one defines a definitive diagnosis. For example, most testing, if positive or negative, only increases or decreases the probability of any one cause being *the* cause in a given patient. It is exceedingly rare that we document a cause in a patient by catching the etiologic event while the patient experiences the syncope. Therefore, when reading the literature, be careful to read how the researchers defined a positive EEG or EPS and then assigned this as the cause for the syncope in a given patient.

2. The first step is to determine what happened right *before, during,* and *after* the syncopal episode. Patients will often use the word dizzy when they mean lightheaded, unsteady without true vertigo, or when they have true vertigo. Be sure you are dealing with true syncope or near

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syncope and be careful about what the patient is really trying to say.

1. *Before:*
   - — Fluid status/environment (probably hot/humid in Augusta in the summer, sweating, etc)
   - — Drugs may cause orthostasis, arrhythmias, anaphylaxis, hypoglycemia, etc; and don't forget ETOH
   - — Presyncopal symptoms: nausea, sweating, light-headed, palpitations, chest pain, vertigo, diplopia, paresis, aura
   - — Activity: bedrest/posture change associated with osthostasis, exercise may induce arrhythmias; micturition/defecation/cough/swallow; postprandial orthostasis is relatively common in the elderly; turning of the head/collar in relation to possible carotid hypersensitivity
   - — Possible stimulants for seizures: stopped meds, bright lights, etc
   - — Emotional state
   - — General: Does the patient have significant cardiac, pulmonary, cerebrovascular disease? Is there a disease or other reason to be orthostatic, etc? Prior syncope or near syncope prior evaluations? Knowledge of these factors will change the pretest probability of different explanations for the syncopal event.
2. *During:*
   Was it witnessed? If so, always question the witness if possible — seizure activity, duration, focal neuro signs, postictal confusion or paresis, loss of bowel or bladder control, drug/ETOH use (the patient may not always be truthful). (Of course, ask the patient these questions as well)
3. *After:*
   - — Postictal confusion?
   - — Focal neuro signs?
   - — Injuries from the event?
   - — Cardiac, pulmonary, orthostatic, glycemic or other important symptoms?

Let's go back to the case for a minute. Suppose further history revealed the following information. In each scenario, consider how your evaluation after the history might be directed.

Scenario A:
The patient says he has no PMH, he felt fine except he had a 24 hour gastroenteritis the day before. He had two beers before playing golf, it was 1:00 PM, he was sweating, no aura/no loss of bowel or bladder control/no postictal state occurred, and he had just changed posture as in the case description. No cardiac or pulmonary disease or symptoms are noted. What's your best guess as to the cause of the syncope? What other testing is needed? Would you hospitalize the patient?

Scenario B:
The patient says he has CAD, he is status-post PTCA to the LAD 6 months ago. He has been getting increasing chest pain in the last month and had some pain the morning of the golf game. They had started play at 8 AM, it was 75 degrees, he had taken his usual isosorbide, diltiazem, and ASA that morning at 6 AM, no ETOH was involved, and he recalls his heart pounding just before he lost consciousness. Now what would you be concerned about? Would this history change your diagnostic approach compared with Scenario A; would it change your mind on whether or not to hospitalize the patient?

The History Is the Key to the Diagnosis and Further Decision-Making

3. The physical examination should focus on key areas most likely to help in establishing a diagnosis.
   - — Blood Pressure: careful routine blood pressure measurement should be carried out. Orthostatic vital signs should also be measured. If you suspect orthostasis enhanced by drug or meal effects, you may want to measure orthostatic vital signs when a medication is having a peak effect or 30-60 minutes after a meal.
   - — Cardiac: carefully assess all pulses to detect vascular disease, arrhythmias, or a discrepancy in arm-arm or arm-leg pulses (why?), thorough heart exam for evidence of pump dysfunction or valvular disease.
   - — Neurologic examination: detailed to assess for signs of seizures and signs of processes that might cause seizures.
   - — Pulmonary examination/leg exam: to detect possible, DVT, PE, and severe pulmonary hypertension.
   - — Carotid sinus massage: must be done carefully with resuscitation equipment and monitoring. Technique and interpretation of results not well standardized, results may be nonspecific, and sensitivity is not known. Should not be a routine part of the examination.

4. The ECG may be helpful in guiding further work-up, but is rarely definitive. The diagnosis is established by the ECG in less than 5% of cases. An ECG consistent with organic heart disease will increase the probability of a cardiac source. Electrolytes may be helpful if one is considering volume depletion or arrhythmias as a cause. An ABG would only rarely be helpful.

5. Tests that may be useful in the work-up of syncope include tilt-table testing, EEG, Holter monitoring, Cardiac event monitoring, Electrophysiologic testing, Echocardiography, and Psychiatric Evaluation. Cerebrovascular studies and brain radiology will rarely be helpful and I believe are grossly over requested. In any given case, it is unusual that you need all tests and the "shotgun" approach is *never* indicated or helpful, and *always* very expensive. Regarding hospitalization — it depends on the suspected cause. For example, in Scenario A above, it sounds like orthostasis, and no other work-up is indicated. Treatment would consist of fluid replacement and taking it easy for a day or two. In Scenario B, the patient needs to be admitted with a diagnosis of crescendo angina with suspected arrhythmia.

6. Common sense answer: If you believe operating a motor vehicle would be unsafe for the patient and/or the public, you should tell the patient not to drive, document this in the chart, discuss with any relatives if possible, and consider notifying the motor vehicle division if a prolonged course is anticipated. When in doubt, err on the conservative side.

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I've Had a Good Run!

Tonight's a trifle chilly and the stars are very bright
A heavy dew is falling, but the tent is rigged alright
You may rest your bones `til morning and if you should chance to wake
Give me a call about the time daylight starts to break.

— Harry H. Morant

"Breaker" Morant is to be shot by firing squad at sun-up. He has been convicted of trump-up charges of shooting prisoners of war. Lord Kitchner made the policy of taking no prisoners, but the order was verbal and no record was kept, hence there was no accountability.

Friends of the court martial are sympathetic towards Morant and one of them offers him a horse on which to escape and he is told that the guards are asleep.

Morant demurs the offer, stating "I've had a good run." He hints there is nothing for him in England or Australia if he should get away. At daybreak, he is executed.

The above story is true and it is a bit more complicated than I indicate, but it presents a nice segue into my retirement and my own "I've had a good run." Of course there is no one, as far as I know, waiting to shoot me at sun-up.

As I hang-up thirty-nine and one-half years of medical practice, there is a virtual roller coaster of emotions and of loss and gain. I shall certainly miss the patients and their individual personalities. And I shall miss medicine and the challenges of diagnosis and therapy. I shall not miss the current interference from insurance companies, Medicare, hospital discharge planners, and now hovering on the horizon, capitation.

Neither will I miss the occasional difficult patient who wants to "drive the bus" but also wants me to write 15 new prescriptions for himself and spouse to mail off to a pharmacy in Texas. Or how about the obese lady who comes in for a blood pressure check, but she is wearing a blouse with sleeves so snug, it will take a general contractor and crane to get the fabric above the antecubital fossa just to apply the cuff.

I have had at least one self imposed inviolable rule. I have never, ever listened to a heart or a set of lungs with the stethoscope applied to a shirt or other clothing. I have insisted that the diaphragm goes on bare skin. On occasions, I must admit, I have had to snake down the stethoscope from above in ladies who are wearing a Peter Pan collar with no accessible zipper or button in the back.

I shall miss the doctor's table in the physician lounge where camaraderie is rampant and medicine so rarely discussed.

I shall not miss the daily reception of notices from nursing homes that want a signature that they have reported to me either a microscopic skin tear or a plethora of bowel movements.

I shall miss informative medical meetings where my younger colleagues are making case presentations of new therapy of old diseases, or even an occasional new disease complex.

I shall not miss the midnight call from the emergency room of the presence of a patient, who for the life of me I cannot recall, that is admitted as a "short stay" because of vague unexplained symptoms. Do I get up and get dressed, see the patient, and put a note on the chart and return home comfortable? Or do I stay in bed, hope everything will be "alright" until morning, but have a fitful night of insomnia and worry?

And what to do with my spare time? I have had retired confreres tell me they are so busy they are surprised they had time to practice medicine. Others say time hangs heavy and finances run thin. Sure, I could play plenty of golf; plenty of bad golf. My game is so poor I may run off what friends I have left. How many times have I heard, "Thanks Milt, but we have

a full threesome"?

I end this treatise with a quote from the book "Goodbye Darkness" by William Manchester. It reflects some beliefs and philosophies that I have tried to emulate. It goes thus:

> . . . "Wickedness was attributed to flaws in individual character, not to society's short comings. To accept unemployment compensation, had it existed, would have been considered humiliating. . . . Debt was ignoble. Courage was a virtue. Mothers were beloved, fathers obeyed. Marriage was a sacrament. Divorce was disgraceful. . . . You assumed that gentlemen always stood and removed their hats when a woman entered a room. The suggestion that some of them might resent being called "ladies" would have confounded you . . . all this led you into battle, and sustained you as you fought, and comforted you if you fell, and if it came to that, justified your death to all who loved you as you loved them. Later the rules would change. But we didn't know that then. We didn't know." (*From GOODBYE DARKNESS by William Manchester. Copyright © 1979, 1980 by William Manchester. By permission of Little, Brown and Company [Inc].)*

So now I close the book on almost forty years of the private practice of medicine. I only hope I have served my patients and my fellow colleagues well.

I've had a good run.

Milton F. Miller, MD

PHYSICIANS BEWARE!

Dealing With Tax-Exempt Healthcare Organizations Can Be Hazardous to One's Financial Health

by James C. Seiffert, Esq

What Physicians Need to Know about the Internal Revenue Service's Intermediate Sanctions Before Transacting Business with Tax-Exempt Healthcare Organizations

Picture this — Dr Smith, a prominent physician intends to sell his private practice to a local nonprofit, tax-exempt hospital where he is a major admitter. As part of the sale, he agrees to become an employee of the hospital with salary and various fringe benefits which include both incentive and deferred compensation arrangements. In addition, he will continue to serve as a member of the hospital's governing board; the same board called upon to approve this transaction. On the surface, this business relationship looks no different than many others that have become commonplace in the healthcare field. Forced to respond to the increased financial pressures, both tax-exempt healthcare providers and physicians view this type of alliance as a "win-win" situation. However, with the recent enactment of a new section of the Internal Revenue Code ("IRC") both Dr Smith and the hospital officials must proceed with care or otherwise find themselves personally subject to certain penalty taxes.

The Taxpayer Bill of Rights 2 ("TBR2"), enacted by Congress on July 30, 1996, created a system of "intermediate sanctions" which operates to assess penalty taxes on individuals participating in transactions with tax-exempt organizations where the economic benefit obtained by the individual exceeds the fair market value of that received by the organization. Much of the impetus behind the creation of this statute arose out of the perceived violations of certain tax exemption standards by nonprofit healthcare providers such as hospitals, HMOs and physician clinics. In an effort to curtail such activity, the Internal Revenue Service (the "IRS") changed its approach; rather than seek to revoke the organization's tax-exempt status as it had in the past, it now focuses on the particular individuals involved in such transactions and assesses penalty taxes on those who are unjustly enriched at the expense of the tax-exempt organization. The enactment of this type of intermediate tax enforcement tool is likely to have a significant effect on the manner in which tax-exempt healthcare providers and physicians transact business with one another.

Overview of the Intermediate Sanctions

TBR2 created IRC Section 4958 which assesses penalty taxes in situations where either a tax-exempt charitable or social organization participates in an "excess benefit transaction." These penalty taxes apply retroactively to all excess benefit transactions occurring after September 13, 1995. Both the recipient of the excess benefit (ie, the "disqualified person") and the exempt organization's board of directors and/or officer(s) who approved the transaction knowing that it involved an excess benefit (ie, the organization manager[s]) will now be personally liable for the payment of the penalty taxes.

IRC Section 4958 applies to any transaction in which the economic benefit provided by the tax-exempt organization to the disqualified person exceeds the value of the services or other considerations received by it in the exchange. The term "economic benefit" is not defined anywhere in the statute but appears to cover only those benefits which have a measurable fair market value. Examples of transactions or financial arrangements in the healthcare field which will draw the scrutiny of the IRS include: (i) the acquisition of a physician's private practice, the receipt of practice support services, or the disproportionate risk assumed by a tax-exempt healthcare organization in a joint venture with physicians; (ii) compensation packages associated with physician recruitment or retention, including incentive compensations and deferred compensation arrangements; and (iii) revenue sharing transactions where the healthcare organization shares its future revenues with a private investor or service provider.

An "excess benefit transaction," which triggers the imposition of the penalty taxes, must involve both a disqualified person as well as an organization manager. A disqualified person is any one who, within a five-year period prior to the transaction, was in a position to exercise substantial influence over the affairs of the

organization. The term also includes a disqualified person's family members and any business in which the disqualified person owns 35% or more. In a break from prior IRS policy, physicians will not be classified automatically as disqualified persons under the law merely because of their status. It is only those physicians that are in a position to exercise substantial influence over the organization who will be subject to the tax. Physicians who are: (i) directors and officers; (ii) major admitters or revenue producers; (iii) representatives of a significant number of the medical staff or a key specialty; (iv) influential with major managed-care providers; or (v) major donors to the healthcare organization will likely be tabbed disqualified persons.

Organization managers, on the other hand, include officers, directors, trustees, and those with similar responsibilities. Titles, alone, do not automatically make one a manager, but rather, it is the individual's actual authority which is relevant. Consequently, only those individuals who regularly exercise general authority over implementing administrative or policy decisions will fall into the category of organization managers.

The penalty taxes assessed against disqualified persons are applied on a two-tier basis. The initial tax is 25% of the excess benefit made available to or for the use of such person. An additional tax of 200% of the excess benefit is assessed against the disqualified person if the excess benefit is not corrected within a specified period of time (ie, 90 days after mailing of a deficiency notice). Acceptable corrective measures include undoing the excess benefit to the extent possible (ie, repaying the money) and taking all other appropriate steps to put the organization back in a financial position, which is no worse than had the transaction been carried out under the highest fiduciary standards. This means that the disqualified person must return the excess benefit received or the organization will be required to take action to collect the excess.

Where the 25% tax is imposed on the disqualified person, a corresponding penalty tax is assessed against the organization manager(s) equal to the lesser of $10,000 or 10% of the excess benefit. However, unlike the disqualified person, an organization manager participating in the transaction must have *actual knowledge* that the particular transaction contains an excess benefit before a tax can be imposed. Actual knowledge will be found to exist where an organization manager negligently fails to ascertain whether the transaction was an excess benefit transaction. An organization manager may escape the tax where the individual establishes that his or her conduct was not willful and he or she exercised ordinary care and prudence in carrying out the individual's duties.

Analysis

A physician may find himself or herself on either side of a business transaction with a tax-exempt healthcare provider that could, potentially, result in the imposition of the penalty taxes under IRC Section 4958. All types of "insider" transactions will now be closely scrutinized by the IRS with the focus and ultimate liability on the participating individuals. Consequently, certain action can and should be taken contemporaneous with the particular transaction to minimize a physician's personal liability.

A physician who, as a potential disqualified person, finds himself or herself engaged in a financial transaction with a tax-exempt healthcare provider should, at a minimum, require written representations and covenants from the organization that it has taken all appropriate steps, contemporaneous with the transaction, to satisfy the elements of the rebuttable presumption of "reasonableness" available under IRC Section 4958. To secure this presumption, the organization must comply with the following: (i) the transaction must be approved by the members of the board of directors unrelated and not subject to the control of the "insider" physician; (ii) in approving the transaction, the board of directors must obtain and rely on contemporary, as well as appropriate, data for the purpose of comparing the particular transaction with similar transactions conducted by similarly situated tax-exempt and taxable organizations; and (iii) the board of directors must adequately document, in writing, the basis for its determination. This presumption is available for both compensation arrangements and valuations of property sold, purchased or transferred. If all three criteria are satisfied prior to closing the transaction, the penalty taxes can be imposed *only* where the IRS has sufficient contrary evidence to rebut the probative value of the data relied on by the parties. In evaluating the reasonableness of compensation or the fair market value of a transaction, the IRS is required to examine the particular transaction against comparable transactions entered into by both taxable and tax-exempt organizations. What this means is that a physician, for example, is not obligated to accept less money merely because he or she contracts with a nonprofit organization. All tax-exempt organizations that engaged in "insider" transactions between September 13, 1995, and January 1, 1997, are well advised to make a good faith effort to conduct a review of their transactions, and to do so with deliberate speed.

A physician may also want to consider, as a condition to the transaction, requiring the tax-exempt organization to indemnify him or her or, in the alternative, require the organization to purchase insurance to cover the potential liability in the event penalty taxes are assessed. However, if this approach is taken, one must

understand that any indemnification payment or insurance premium payment must be included as part of a physician's compensation from the start, and the physician's total compensation which now includes this additional payment must be "reasonable."

For the physician who serves in an executive capacity or as a member of the board authorizing these types of transactions, certain steps should also be taken to insulate him or her from personal liability. First and foremost, the tax-exempt organization should have in place a "conflict of interests" compliance plan specifically designed to minimize the personal exposure of those executives, board members and other persons potentially subject to the penalty tax. This plan should include the identification of all conflicts of interest and a procedure for approval of all insider business transactions and compensation decisions which incorporates the elements of the rebuttable presumption of reasonableness. With respect to the conflicts of interest plan, it should specifically address: (i) the disclosure of interested parties and the specific material terms of the transaction; (ii) a procedure for determining whether the financial interests of the interested parties result in a conflict of interest; and (iii) a procedure for sufficient recordkeeping. Once established, this policy must be distributed to all officers, trustees, and committee members with board-delegated powers. The organization should also be required to review whether its existing directors and officers insurance insures against the penalty taxes.

Conclusion

With the enactment of IRC Section 4958, physicians finding themselves on either side of a business transaction with a tax-exempt healthcare provider should make sure the proper procedures are in place to insulate them from the imposition of its penalty taxes. Both the disqualified person and the board member have a vested interest in seeing that the particular business transaction does not contain any improper or excessive economic benefits. To the extent physicians are not proactive in this regard, the penalty taxes of IRC Section 4958 could prove hazardous to their financial health.

Mr Seiffert practices law with the firm of Stites & Harbison, 400 W Market St, Suite 1800, Louisville, KY.

Surgical Management of Intrathoracic Goiter

I read with interest the communication to the *KMA Journal*, dated October 1997, titled, "Surgical Management of Intrathoracic Goiter," by Sibu P. Saha, MD, et al. I must say that I disagree with most of his indications for removal of a substernal goiter and the procedure proposed.

He reports 18 cases of intrathoracic goiter, 12 which were substernal and 6 in the poster mediastinal position. He recommends substernal goiters be removed through a midline sternum-splitting incision and the posterior goiters be removed through a right thoracotomy. It should be noted that 4 of his patients were asymptomatic at the time of surgery, and it is unclear whether these patients had goiters in the anterior or posterior position.

Substernal goiter is not really a rare entity. I certainly agree with Dr Saha and co-authors that both the anterior and posterior goiters represent an extension from the neck. Sole blood supply to the goiter from the mediastinum (aorta) is very rare. Contrary to what is stated in his communication, a diagnosis of the situation can be made in 90%+ of the time on the basis of *physical examination* and with plain x-rays of the chest. Physical examination is not mentioned in the article at all. Attention is directed to specialized procedures. A CT scan of the chest will support the diagnosis in a very considerable proportion of the patients.

The article states that carcinoma may involve at least 16% of cases. In my opinion and in the opinion of others in the literature, the potential for malignant degeneration is not considered significant enough to warrant the removal of all adenomatous goiters.[8] The literature that I reviewed, as well as the cases reported in this study and in my experience, show no removed goiter was carcinomatous.

Symptomatology as an indication for removal has become problematic. In my opinion, they should generally demonstrate some evidence of tracheal compression, as well as, perhaps, the dry, hacking cough described.[1-9] Certainly a goiter increasing in size on follow-up would require removal. In my experience, as well as that of others, these patients are frequently asymptomatic. The patients referred to me with this problem were initially evaluated by their private physicians and, because of an abnormal chest x-ray, possibly showing a mediastinal mass, they were sent to me for thoracic surgical opinion. In a number of the patients, the characteristic x-ray or CT scan or both, coupled with a good physical examination, usually led to a recommendation of no further treatment other than observation.

The most serious issue I have with the paper is the method of removal of a substernal goiter. It is almost universally accepted that the primary approach is through a collar incision[1-9] with mobilization and delivery of the gland through the thoracic inlet. A midline sternal-splitting incision was rarely needed. Literature would appear to support a collar approach even when a true mediastinal goiter is diagnosed[4] or the goiter be in a posterior position. Contrary to his statement concerning "morcellation of the gland," there was no need for this.[6]

It should be mentioned, and perhaps less importantly, that the thyroid tissue within the chest, particularly as pertains to the posterior distribution of a goiter, may be the only thyroid tissue the patient has, and removal of it may render him or her hypothyroid on medication for the rest of their life.[6,9] Hyperfunction as an indication for removal must be as rare as hen's teeth. Again, thoroughly adenomatous goiters, cervical in position, become large but very rarely malignant. Their removal involves symptoms of tracheal compression or cosmetic problems. It is quite likely the cosmetic problems predominate. Why should mediastinal goiters behave any differently than cervical goiters with regard to malignancy?

I believe the article does not represent the standard of care and management of this problem, especially with regard to the chosen surgical approach. In these days of "limited is better," I am rather surprised that the effective transcervical approach should be cast aside in such a manner. I would advise Dr Saha's group to refer such cases to a general surgeon familiar with both a conservative approach and the transcervical operation when indicated.

James H. Simrall, MD
5406 Navajo Road
Louisville, Kentucky 40207
502/896-6703

References

1. Hsu B, et al. Recurrent substernal goiter: Incidence and management. *Surgery*. 1996;120(6): 1072-1075.
2. Alvarez K, et al. Surgical treatment of cervicomediastinal goiter. *Arch Bronconeumol.* 1997 Feb; 33(2):84-88.
3. Fadel E, et al. Intrathoracic goiter. 62 surgically treated patients. *Presse Med.* 1996 May;49(5):425-429.
4. Uematsu M, et al. A case of intrathoracic goiter. *Kyobu Geka.* 1996 May;49(5):425-429.
5. Sabiston. *Textbook of Surgery* 10ED 1972:646
6. Sabiston. *Textbook of Surgery* 15ED 1997:626-629
7. Swartz. *Textbook of Surgery* 1ED 1969:1642
8. Swartz. *Textbook of Surgery* 2ED 1974:1454-1455
9. Swartz. *Textbook of Surgery* 6ED 1994:664-665

Dr Saha replies:

We thank Dr Simrall for his interest in our recent article entitled, "Surgical Management of Intrathoracic Goiter." Dr Simrall has made multiple comments that are relevant to substernal goiter, but not to intrathoracic goiter. Fourteen patients presented with various symptoms, including shortness of breath, dysphagia, dry cough and respiratory failure. Four patients, who were asymptomatic, showed evidence of tracheal deviation and compression. We agree with his assessment that clinical examination coupled with CT scan could clinically diagnose a substernal goiter. However, true intrathoracic goiter is not amenable to clinical examination, such as palpation. CT scan is extremely beneficial in the diagnosis of both substernal and intrathoracic goiter. However, there is no substitute for tissue diagnosis. In his letter, he challenges the incidence of malignancy in adenomatous goiter. In his own reference in the Sabistan Text Book of Surgery (15th Edition, 1997), it is reported to show 4% to 17% incidence of carcinoma, however thought to be so only in surgical cases. He has expressed serious concern about the surgical incision. Again, his comments are very pertinent to substernal goiter and not for intrathoracic goiter. We also use collar incision for removal of substernal goiter. We would like Dr Simrall to revisit Page 1642 of the *Text Book of Surgery* (6th Edition, 1994) by Swartz. The last sentence of the paragraph on intrathoracic goiter reads, "often a full sternotomy is necessary."

Sibu P. Saha, MD, et al

IN REMEMBRANCE

Robert Joseph McCabe, MD
1921-1997

My friend and colleague Bob McCabe was born in Covington, Kentucky on March 19, 1921. He was a graduate of Covington Latin School in 1937, Xavier University in 1941, and the University of Cincinnati College of Medicine in 1944. After a year of internship at Cincinnati General Hospital in 1944-45, he served two years as a captain in the US Army Medical Corps during WWII. He then practiced general medicine in Covington for seven years followed by a residency in dermatology at University Hospital, Cincinnati, from 1954-1957.

Bob was a member of the Northern Kentucky Medical Society, the Kentucky, Southern, and American Medical Associations, the Cincinnati Dermatological Society, and the American Academy of Dermatology.

I first met Bob in 1956 while visiting the Cincinnati residency program. He invited me to attend the residents' journal review, and I was immediately impressed with his quiet scholarship and his grasp of dermatologic literature. He was far ahead of the times with his expertise in performing the Tzank test for diagnosing herpetic eruptions and in allergic patch testing of the skin.

Bob McCabe was a consummate practitioner of dermatology for over 40 years in Northern Kentucky. A legion of loyal patients loved him because of his integrity to their needs; colleagues admired him because of his integrity and commitment to sound medical practice. He epitomized traditional Hippocratic and Oslerian ethics and thereby served as a splendid role model for the many physicians who knew him.

The passing of this kind and gentle man leaves a great void in what is good in contemporary medicine, but his faithful and honest ministry to patients will abide and inspire for generations to come.

Bob is survived by his devoted wife Marilyn, three daughters, four sons, twelve grandchild, and one great grandchild. May the Lord comfort them in this time of bereavement.

Smith H. Gibson, MD
Covington, KY



Aroona Dave

To Promote Coalition Building Hand to Hand

"SAVE" our focus '97-'98 continues. "Hands Are Not For Hitting" and "I Can Choose" booklets are being distributed to K-3 children in 12 organized counties public schools and more. KMA PE Committee has taken the lead by contributing funds to purchase these. AMA Alliance fully supports this by giving substantial discount and printing. In addition to the financial support they are giving the project, the Public Health Commissioner's office also is distributing the materials to the schools through school health coordinators.

Trover Foundation, Family Advocacy Center, local Health Department of Hopkins County, Perry County, Pike County Domestic Violence Shelter, SMA Auxiliary are all very significant contributors to the project. Also in honor of all the volunteers at Ky PTA, where children come first, a contribution has been made.

"SAVE" is a national program that teaches children conflict resolution without resorting to violence. Alliance members can show that they truly care for the future of our children by being involved in this project — in their counties. This is a good PR for us and is good for our children. If we reach even 10 or 100 children through this program, it will make a big difference in stopping the violence!!

WE ARE IN THIS TOGETHER!

Tri-County Visit by
AMA Alliance Field Director
Molly Krafka
March 9th & 10th, 1998

I am really looking forward to upcoming event in March 9th & 10th, 1998. Molly O. Krafka is going to address Jefferson County Medical Society Alliance members and resident physician/medical student spouses on the subject of "Medical Marriage."

She will inform the Warren County and Daviess County members about "What is an Alliance?"

Fondly,

Aroona

Aroona



Molly Krafka



Angela DeWeese

KMA-KMAA Legislative Day at the Capital

The Kentucky State Legislature meets in regular session once every two years. Whether Kentucky citizens are passive or active in regard to their government, there always seems to be a sense of anticipation and expectation about issues and laws which affect all of us when the Legislature is in session. Especially in the field of medicine, there is a feeling of urgency about many issues which need to be addressed. Insurance reform, patient protections, physician reimbursements, standards of care, and licensing and professional regulations are just a few of the issues facing lawmakers.

For the past several years Alliance members and their spouses/guests have been privileged to be part of the KMA-KMAA DAY in Frankfort. This year's event on January 28 at the Capitol Plaza Hotel proves to be another educational and worthwhile experience. At the time of this writing, the scheduled speakers include Governor Paul Patton, Senate President Larry Saunders, Speaker of the House Jody Richards, Senator Dan Kelly, and Secretary of Human Services John Morse. Doctors Bill Monnig and Wally Montgomery, Alliance representatives, and others are also on the agenda. Afternoon time will be free for visiting legislators or attending House or Senate Sessions.

Alliance members and their guests find this day to be a most profitable way to support the medical profession. The format is easy to follow. The presentations are not long. The information is designed to broaden our knowledge of how legislation is developed and how government works. The day begins in the early AM, but a continental breakfast and a seated luncheon give everyone time to visit and review the day's events. Both of the meals are complimentary and are a gracious way for KMA to show appreciation to the Alliance for their support in the year's legislative endeavors.

Permit me to close by thanking all County Legislative Chairpersons for their support this year. Special thanks to Joan Slattery Burke of Lexington who has worked diligently for our Alliance as Phone Bank Chair.

Also, I once again want to thank Governor Paul Patton and his wife Judi for taking part in the photo session with Alliance members after Governor Patton signed a proclamation naming October 8, 1997, SAVE DAY IN KENTUCKY. Their efforts to stop the violence in our state and nation are appreciated by all Kentuckians.

Have a wonderful 1998. Let's keep working for GOOD GOVERNMENT!

Angela DeWeese
Legislative Affairs Chairman

"Alliance members and their guests find this day to be a most profitable way to support the medical profession....The information is designed to broaden our knowledge of how legislation is developed and how government works."

1998

MARCH

9-13 — Cardiology at Cancun 1998, sponsored by the American College of Cardiology. Contact: Extramural Programs Dept, American College of Cardiology, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; phone 800/253-4636, ext 695; fax 301/897-9745.

22-24 — Spirituality Healing in Medicine — IV & V, sponsored by The Institute of Religion, Texas Medical Center, The Westin Galleria Houston, Houston, TX. Contact: Harvard Medical School, MED-CME, PO Box 825, Boston, MA 02117-0825; phone 617/432-1525; e-mail: hms-cme@warren.med.harvard.edu.

APRIL

24-May 1 — 57th American Occupational Health Conference, John B. Hynes Veterans Memorial Convention Center, Boston, MA. Contact: AAOHN in Atlanta, 404/262-1162 X110, and ACOEM in Arlington Heights, IL, 847/228-6850 X152.

28-May 3 — Back to the Future...a Renaissance in Endocrinology (Seventh Annual Meeting and Clinical Congress of the American Association of Clinical Endocrinologists and the American College of Endocrinology Induction of Fellows), Buena Vista Palace, Orlando, FL. 44 hours Category 1 CME. Contact: AACE, 904/353-7878; FAX 904/353-8185; on-line — http://www.aace.com.

JUNE

23-July 5 — "American Medicine in a Critical Perspective" — Norwegian Fjords Study Cruise aboard Holland America Line's ship, the ms Rotterdam VI, jointly sponsored by the Florida Medical Association and Continuing Education, Inc. Twenty (20) hours Category 1 CME activities. Contact: 1/800/926-3775.

25-28 — 1998 CMRS Annual Society Meeting Clinical Magnetic Resonance Society, Disney's Yacht & Beach Club Resorts, Lake Buena Vista, FL. Contact: phone 800/823-2677 or 513/221-0070; fax 513/221-0825; e-mail: cmrs@one.net.

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Stephen Z. Smith, MD



Milton F. Miller, MD

Journal Editors Honored by House of Delegates

In 1997, Assistant Scientific Editor Stephen Z. Smith, MD, and Assistant Editor Milton F. Miller, MD, each celebrated his 20th Anniversary as a member of the Editorial Board of *The Journal of the Kentucky Medical Association.*

In recognition of their long and distinguished service to the profession, the Association, and the Editorial Board, the 1997 KMA House of Delegates honored each with a special tributary resolution. The resolutions were read before the House during the 1997 KMA Annual Meeting, and each was adopted as written.

Both of these exemplary Editors are recognized for their fine editorials. Dr Smith also serves as Book Review Author and has contributed many concise, insightful reviews. Dr Miller has been widely acclaimed by several publications which have reprinted many of his editorials.

The devotion and outstanding efforts of Drs Smith and Miller, along with the contributions of their Editor colleagues, has ensured the integrity of *The Journal* as a vehicle for outstanding articles to improve the scientific and medical knowledge of Kentucky physicians. During the tenure of these Editors, *The Journal* has won numerous awards, and we are grateful for their many contributions.

In December 1997, Dr Miller announced his retirement from the active practice of medicine, and, alas, his resignation from the Editorial Board. (See his editorial on page 63 of this issue.) The Kentucky Medical Association, Editor A. Evan Overstreet, MD, and the Board and staff of *The Journal* wish Dr Miller a happy and productive retirement.

Actions of Reference Committee on Amendments to Constitution and Bylaws

AMA Interim Meeting, December 1997

The AMA has just celebrated its 150th as the voice of organized medicine in the United States. I have had the privilege to serve as your alternate delegate to the Reference Committee on Amendments to Constitution and Bylaws. It is imperative that the work of the AMA be forwarded to the Kentucky Medical Association members. My goal today is to share with you some insights which came before my reference committee in December 1997.

This committee deals with issues of how the AMA does its daily business and how the AMA conducts the annual and interim meetings. Therefore, one of the adopted reports as amended asks that a simple majority in the Official Call of voting members of the House of Delegates shall constitute a quorum. This will allow the House of Delegates to proceed with the business of the House even if the total number of voting members present should drop below the present rule of 200.

A highly debated issue was financial incentives and the practice of medicine. All physicians would agree that if financial incentives encourage efficient practice patterns consistent with ethical and scientific standards of care, then they are both appropriate and timely. However, there is the potential for all incentives to extend their scope of influence beyond basic practice trends to affect individual clinical decisions. The practice of medicine requires physicians to be free of financial conflicts that can affect clinical objectivity to the detriment of individual patient advocacy. It is critical for the profession to establish limits on the use of incentives in order to preserve the ability of physicians to fulfill their obligation to each patient. The Council on Ethical and Judicial Affairs affirms that the primary responsibility to inform patients of the financial incentives that could impact on the level and type of care they receive should be assumed by the health plan. However, the Council further stated that physicians should be prepared to discuss with patients any financial arrangements that could impact patient care.

These are just a few of the important issues discussed and actions taken at the 1997 AMA Interim Meeting.

Baretta R. Casey, MD
AMA Alternate Delegate

Reference Committee on Amendments to Constitution and Bylaws

ADOPTED

1. Board of Trustees Report 21 — Specialty Organization Representation in the House of Delegates — Recommendations adopted and report filed.
2. Council on Constitution and Bylaws Report 1 — Responsibility for Planning Activities of the American Medical Association.
3. Council on Constitution and Bylaws Report 2 — Speaker and Vice Speakers of the House of Delegates — Tenure.
4. Council on Ethical and Judicial Affairs Report 2 — Patenting the Human Genome.
5. Council on Ethical and Judicial Affairs Report 3 — Ethics Consultation.
6. Council on Ethical and Judicial Affairs Report 6 — Subject Selection for Clinical Trials.
7. Resolution 3 — Restrictive Covenants.
8. Resolution 6 — Calendar Year Terms for AMA — YPS Delegates and Alternates.

ADOPTED AS AMENDED OR SUBSTITUTED

9. Council on Constitution and Bylaws Report 3 — Definition of Quorum.
10. Board of Trustees Report 24 — Specialty Organization Representation in the House of Delegates — American Society of Cytopathology Compliance with 5-Year Review Criteria.
11. Council on Ethical and Judicial Affairs Report 1 — Financial Incentives and the Practice of Medicine.
12. Council on Ethical and Judicial Affairs Report 5 — Sale of Non-Health Related Goods from Physicians' Offices.
13. Council on Ethical and Judicial Affairs Report 7 — Invalid Medical Treatment.
14. Resolution 4 — Professional Courtesy.

REFERRED

15. Council on Ethical and Judicial Affairs Report 4 — Physicians' Political Communications with Patients and Their Families.
16. Resolution 2 — Patient-Physician Relationship.
17. Resolution 7 — Definition of a Resident.
18. Resolution 8 — Principles of Medical Ethics — was not adopted.
19. Council on Constitution and Bylaws Report 4 — Nominations for Elected Councils.

KMA Board of Trustees — December Meeting

The KMA Board of Trustees met on December 17-18, 1997, at the KMA Building in Louisville.

KMA President, C. Kenneth Peters, MD, presented his goals for 1998: a successful legislative session, two regional trustee district meetings, and a strategic planning seminar. The first regional trustee district meeting is scheduled for April 22, 1998, at the Riverpark Center, Owensboro. A strategic planning seminar is scheduled for May 27-28, 1998, in Shakertown.

Donald C. Barton, MD, Senior Delegate to the AMA, summarized the 1997 AMA Interim Meeting in Dallas. Ardis D. Hoven, MD, Lexington, has been nominated for a position on the AMA Council on Medical Services; and Bruce A. Scott, MD, Louisville, is running for the Young Physicians Slot on the AMA Board of Trustees.

Additional reports were presented by William P. VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Chair, KEMPAC Board of Directors; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner for Health Services; Mrs Aroona Dave, Alliance President; James B. Holloway, MD, Acting Medical Director, AdminiStar; and Danny M. Clark, MD, President, Kentucky Board of Medical Licensure.

A progress report on the Regional Partnerships was presented. Larry N. Cook, MD, Chair, Department of Pediatrics, University of Louisville School of Medicine, reported that start-up began in November in Region 3 with 43,000 enrollees, with another 18,000 expected in January. Over 500 primary care physicians and approximately 1200 specialists have signed contracts. James R. Bean, MD, Lexington, reported that Region 5 is operating with 71,000 enrollees at present and another 25,000 are expected to enroll by April 1. Approximately 400 primary care physicians and 750 specialists have joined the partnership in Region 5. Richard T. Heine, PhD, Manager, Medicaid Waiver Project, reported on developments in the remaining regions.

Robert R. Goodin, MD, Immediate Past Chair, KMA Physicians Plan, Inc, reported that the KMAPP Board of Directors, at its meeting on October 30, 1997, recommended that efforts to develop a KMA-sponsored managed care product be discontinued as a result of a survey conducted by Ernst & Young, which indicated that financial and business barriers made such a venture unfeasible. The KMAPP Board recommended that KMAPP continue with new focus areas such as a managed care support service, leadership courses for physicians, and managed care seminars.

The Board adopted Agenda B to implement all actions of the 1997 House of Delegates.

Two new committees, the Ad Hoc Committee on Alternative and Unconventional Medicine and the Ad Hoc Committee to Recommend a Section on International Medical Graduates were appointed. Kenneth R. Hauswald, MD, Ashland; Eugene H. Shively, MD, Campbellsville; and Robert C. Hughes, MD, Murray, were appointed to the KMIC Board Nominating Committee.

Legal Counsel updated the Board on the federal health benefit plan for mail carriers and lawsuits challenging Kentucky's Any Willing Provider law. The Any Willing Provider law is not being enforced, pending a decision in the suit.

Reports were given by the Committees on National and State Legislative Activities, the Public Education Committee, Committee on Medicaid Managed Care, Ad Hoc Committee on Faculty Membership, Continuing Medical Education Committee and the Committee on Child and School Health. The first Fraud and Abuse seminar, recommended by the Committee to Investigate Changing Trends in Medicine, is scheduled for February 5, 1998, at KMA Headquarters.

It was noted that the 1998 Annual Meeting will be held in Louisville September 20-24. The theme for the meeting is "The Team Approach to Healthcare: The Physician's Role."

The next meeting of the KMA Board of Trustees was scheduled for April 8-9, 1998, at the KMA Building.



KMA President C. Kenneth Peters, MD, was presented a Journal plaque commemorating his inaugural issue.

PEOPLE

Peter Hasselbacher, MD, professor of medicine and the first faculty fellow in the University of Louisville's partnership with the Kentucky Center for Public Issues, has been selected as one of six Robert Wood Johnson Health Policy Fellows nationally.

Lt Governor Stephen L. Henry, MD, was the recipient of the 1997 Mary C. Bingham Land Conservation Award given by the Future Fund Land Trust.

UPDATES

Team of Specialists Aids Ukrainian Burn Victim

A 12-year-old Ukrainian boy with severe burns covering half his body is being treated at the University of Louisville Hospital. During his approximate 10-week stay in Louisville, the patient, Ruslaan Litvinchuk, will receive extensive reconstructive surgery and physical therapy. He was injured when his clothes, which had been soaked in gas by other boys, caught fire.

Ruslaan's trauma physician, Ikram Mzoughi, MD, and a translator, Miriam Useinova, accompanied him to Louisville. During their stay, Dr Mzoughi will work as a fellow at U of L Hospital to learn the latest techniques in treating severe burn victims. U of L's burn unit treats patients suffering from second- and third-degree burns, smoke inhalation, chemical burns, and electrocution injuries.

A team of specialists has volunteered to treat Ruslaan at no charge. In addition, U of L Hospital and Frazier Rehab Center will make their facilities and staffs available at no charge. Caritas Health Services donated air fares to bring the three here and return them home. The medical team that will evaluate and treat Ruslaan includes:

— **Gordon Tobin, MD,** director of plastic and reconstructive surgery, medical school;
— **Benjamin Rigor, MD,** chair of anesthesiology, medical school;
— **Linda Gleis, MD,** assistant clinical professor and former director of the physical medicine and rehabilitation residency program;
— **Ronald Lehocky, MD,** assistant clinical professor of pediatrics; and
— **Anna Invenenko, MD,** a psychiatry resident working under the supervision of instructor **Sandra Elam, MD,** of psychiatry.

Louisville dentist **Shellie Branson, DMD,** has agreed to provide dental care.

Ruslaan came to the attention of the Jefferson County Medical Society's "Supplies Over Seas" program, a humanitarian effort that recycles medical supplies and drugs to some of the world's neediest communities. Among the organization's contacts is missionary Kathryn McKewen, a retired Leitchfield, Ky, nurse who established a clinic in Simferopol, Ukraine. McKewen relayed Ruslaan's plight to JCMS, which arranged for the youngster to be treated here.

Dr Tobin said that the boy's grafts have healed, his newly grown skin has begun to scar and shrink — typical side effects for burn victims. The effect has hindered movement of one eyelid, all limbs and skin on the neck and face.

Dr Tobin said he is excited that he and his colleagues will be able to train Dr Mzoughi in American burn treatment and trauma techniques. Dr Mzoughi then can take the knowledge back to Ukraine.

"Providing instruction on burn care has a tremendous impact in underdeveloped countries because the best burn care results from proper techniques, not technology," Dr Tobin said. "You don't need expensive equipment like heart-lung machines and laser devices to provide outstanding care."

The Jefferson County Medical Society Alliance arranged for Ruslaan, Ms Useinova, and Dr Mzoughi to stay at Hospital Hospitality House throughout their stay in Louisville. Alliance members and various local groups are assisting with hospitality, providing food, transportation, child care, clothing, incidentals, and companionship with peers throughout their stay.

Ruslaan Litvinchuk has been abandoned by his family, but a woman in Simferopol wishes to adopt him upon his return.

Kentucky Begins Surveillance of Occupational Burns

Occupational burns place a tremendous burden on the workforce, the medical community, and employers in Kentucky. In cooperation with the Kentucky Department for Public Health (KDPH), the Occupational Injury Prevention Program (OIPP) at the Kentucky Injury Prevention and Research Center (KIPRC) is establishing a statewide occupational burn surveillance system to identify causes and trends of work-related burns and monitor progress toward reducing these injuries. Funding for this project is provided by the National Institute for Occupational Safety and Health (NIOSH). Case identification began in January 1998 and will continue for 5 years.

According to a report from KIPRC, between 1994 and 1996, 52 workers died from burns, explosions or electrocutions. Most of these workers were less than 40 years old. In 1995, 1,195 Workers' Compensation claims were filed for work-related burns; 55 workers were hospitalized. The industries with the most claims were retail trade (34%) and manufacturing (23%). About 68% of the claims resulted in lost work time and 32% resulted in temporary disability. There

was an average of 6.4 days lost from work, and the total value for these claims was more than $2.6 million.

This initiative for a statewide burn injury surveillance system focuses on identifying risk factors associated with the workplace (eg, the task, environment, machine, worker) in order to develop injury prevention strategies. Using epidemiologic principles, the specific aims of the project are to:

- Identify the incidence of burns as an occupational injury (including thermal, electrical, chemical, friction, and radiation burns)
- Identify trends in burn cases quickly
- Develop and implement interventions to reduce the incidence of burn injury
- Evaluate the economic savings of interventions

Cases will be identified primarily through hospital burn units, emergency departments, the Kentucky Department of Workers' Claims, Kentucky Employers' Mutual Insurance, and death certificates.

KIPRC believes that members of the medical community, most notably private physicians and emergency department personnel, are in an excellent position to notify OIPP of work-related burn cases presenting for treatment; that only through the active involvement of health care providers can this project succeed in identifying and ultimately reducing the incidence of these traumatic injuries; and additionally, that practitioners will be an invaluable part of the project by disseminating prevention information to patients whose work histories indicate a potential for burn injuries.

KIPRC advises that data generated from burn surveillance activities will be disseminated to workers and employers, trade organizations, health professionals, public agencies, and the general public via news media.

Surveillance is a key component of occupational injury control. It provides baseline data and the opportunity to monitor trends. Over the next 5 years, the occupational burn injury surveillance project will enable KIPRC to identify risk factors for burn injury, implement effective prevention strategies, and reduce the incidence of these costly injuries in Kentucky.

For more information please contact Amy Scheerer, Project Manager, at 606-257-6712 or 1-800-204-3223.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

John Timothy Garner MD — FP
539 Eden Place, Ashland 41101
1994, W. Virginia U

Daviess

John D Robinson, MD — P
1000 Industrial Dr, Owensboro 42301-8715
1977, U of Missouri, Columbia

Fayette

Tony W Dotson DO — OBG
4745 Hartland Pkwy, Lexington 40509
1997, Chicago Homeopathic Med Col

Floyd

David J Jenkinson MD — ORS
485 E Dorton Blvd, Staffordsville 41256
1974, Queens U of Belfast

Green

Thomas A Castillo DO — OPH
262 Creason Lane, Greensburg 42743
1977, Chicago Col of Osteopathy

Jefferson

Paul A Atkins MD — IM
5030 Fertig Creek Rd, Floyd Knobs 47119-9212
1992, Indiana U

Robert T Barowsky MD — OPH
2817 Eastwood Fisherville Rd, Fisherville 40023-9727
1980, U of Wisconsin

Ricky S Collis MD — AN
6613 Northridge Cir, Louisville 40241-6533
1992, U of Louisville

Tyrone L Daniels MD — C
1400 Twin Ridge Rd, Louisville 40242-3817
1983, U of Iowa

Dale S Horne MD — NS
6420 Dutchmans Pkwy Ste 190, Louisville 40205
1990, Washington U, St. Louis

Diana G Irvin MD — IM
1139 Cherokee Rd, Louisville 40204
1982, U of Kansas, Lawrence

Mary E Lacher MD — PD
7003 Shallow Lake Rd, Prospect 40059
1985, Creighton U, Omaha

McCracken

Yale R Smith MD — AN
2507 Broadway, Paducah 42001
1985, U of Dominica, Ross U

Mercer

Steven C Hall MD — FP
PO Box 9, Harrodsburg 40330
1988, Dalhouse U, Canada

In-Training

Fayette

Andrea S Kristofy MD — AN
Adam Wooten DO — P

Kenton

Corey Gallus DO — FP
David Frederick Lowe MD — FP
Michael P Minning MD — FP
Rhonda R Pfaff, MD — FP

DEATHS

Robert L. McKenney, MD
Falmouth
1925-1997

Robert L. McKenney, MD, a general practitioner, died August 29, 1997. Dr McKenney graduated from the University of Louisville School of Medicine in 1954 and was an active member of KMA.

David P. Edmundson, MD
Mount Sterling
1912-1997

David P. Edmundson, MD, a retired general practitioner, died August 31, 1997. Dr Edmundson was a 1936 graduate of the University of Tennessee College of Medicine and a life member of KMA.

Robert C. Smith, MD
Newport
1919-1997

Robert C. Smith, MD, a retired psychiatrist, died September 5, 1997. A 1945 graduate of the University of Cincinnati College of Medicine, Dr Smith was a life member of KMA.

Harold B. Graves, MD
Harlingen, TX
1911-1997

Harold B. Graves, MD, a retired OB-GYN, died October 6, 1997. A 1937 graduate of Homeopathic Medical College of Missouri, Dr Graves was a life member of KMA.

Robert J. McCabe, MD
Newport
1921-1996

Robert J. McCabe, MD, a dermatologist, died October 12, 1997. Dr McCabe was a 1944 graduate of the University of Cincinnati College of Medicine, and an active member of KMA.

Mario W. Cartaya, MD
Campbellsville
1914-1997

Mario W. Cartaya, MD, a retired general practitioner, died October 12, 1997. A 1947 graduate of the University of Havana School of Medicine, Dr Cartaya was a life member of KMA.

Daniel H. Boeh, MD
Ft. Thomas
1910-1997

Daniel H. Boeh, MD, a retired general practitioner, died November 13, 1997. Dr Boeh was a 1936 graduate of the University of Cincinnati College of Medicine and a life member of KMA.

Thomas F. Whayne, Sr, MD
Lexington
1905-1997

Thomas F. Whayne, Sr, MD, a retired preventive medicine physician, died November 18, 1997. A 1931 graduate of Washington University School of Medicine, Dr Whayne was a life member of KMA.

Lee A. Heine, MD
Louisville
1916-1997

Lee A. Heine, MD, a retired family practitioner, died November 29, 1997. Dr Heine graduated from the University of Louisville School of Medicine in 1960 and was a life member of KMA.

Jorge Matallana, MD
Louisville
1929-1997

Jorge Matallana, MD, a pulmonary diseases physician, died December 2, 1997. A 1954 graduate of National University, Dr Matallana was an inactive member of KMA.

Herman R. Moore, MD
Louisville
1920-1997

Herman R. Moore, MD, a retired general surgeon, died December 13, 1997. Dr Moore graduated from the University of Louisville School of Medicine in 1944 and was a life member of KMA.

Impaired Physicians Program
9000 Wessex Place, Suite 305
Louisville, KY 40222
Phone: 502/425-7761; Fax 502/425-6871



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Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted to one of the state's accredited medical schools. The Fund offers a $12,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. Counties considered to be rural and critical are determined by the RKMSF annually. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately $4 million to over 600 medical students. The deadline date for filing an application is ***April 1, 1998***. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222, or call 502.426.6200.

Are You Relocating to a Critical Area in Kentucky and Have Educational Debt???

The Rural Kentucky Medical Scholarship Fund, Inc offers an additional program to continue to address the problem of maldistribution of physicians — the Establish Practice Grant Program (EPGP). This program enables primary care physicians who are beginning a practice in a critical area of Kentucky in obtaining assistance in repaying educational debt.

The EPGP offers $10,000 per year to a licensed full-time physician who has practiced in a critical county of Kentucky as designated by the RKMSF. The EPGP is limited to five participants per year. The program currently has two vacancies for 1998.

If you are interested in additional information and an application, please contact the Rural Kentucky Medical Scholarship Fund, Inc EPGP office at 502.426.6200, or at 4965 US Hwy 42, Suite 2000, Louisville, KY, 40222.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

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Medical Protective Co 42

National Committee to Prevent Child Abuse 81

National Rural Health Assn 72

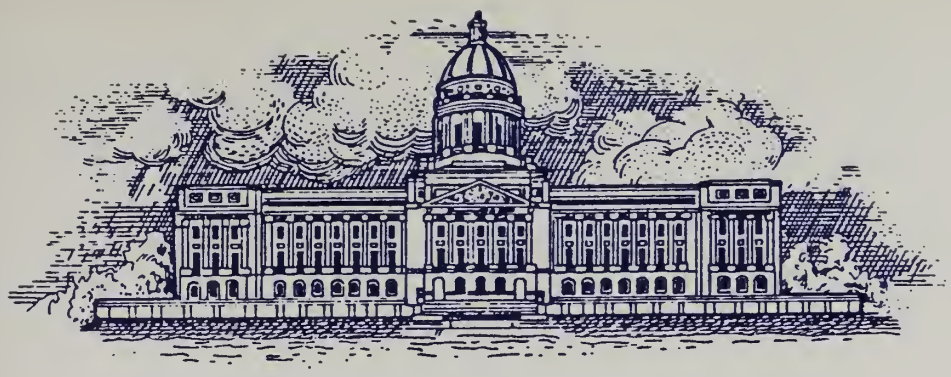
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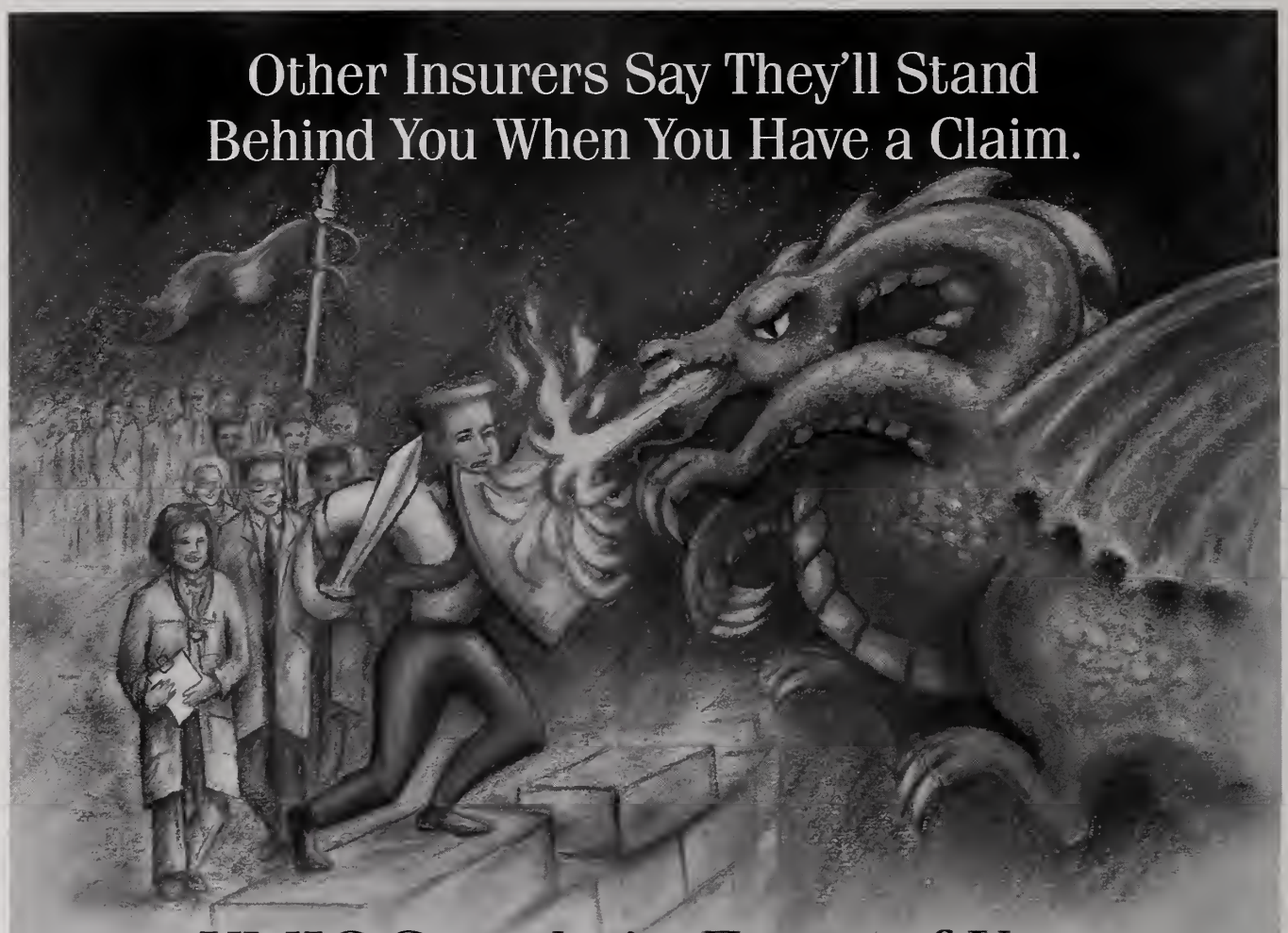
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VOLUME 96, NUMBER 3

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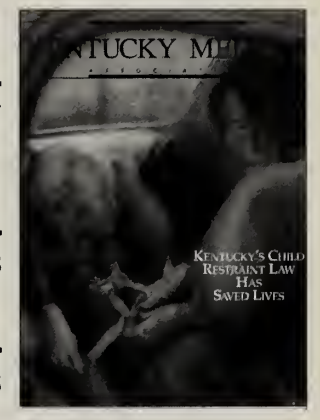
JOURNAL OF THE

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VOLUME 96, NUMBER 3 MARCH 1998

COVER STORY	Kentucky's Child Restraint Law Has Saved Lives: A 20-Year Review of Fatalities Among Children (Aged 0-4) as Motor Vehicle Occupants *L. A. Goldstein, PhD; C. W. Spurlock, PhD*	**97**
SCIENTIFIC	Chronic Cavitary Pulmonary Sporotrichosis: Efficacy of Oral Itraconazole *Jesus Ramirez, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD*	**103**
SPECIAL ARTICLE	Financial Planning Considerations at Retirement *Robert J. Cole, Jr, CLU, ChFC, CFP*	**106**
EDITORIAL	Telemedicine *Stephen Z. Smith, MD*	**109**
ASSOCIATION	*Monitoring Medicine*	**91**
	1997-98 New Officers' Profiles	**112**
	Highlights of AMA House of Delegates 1997 Interim Meeting	**114**
	News	**117**
DEPARTMENTS	President's Page	**89**
	Advertisers' Guide	**122**
	Alliance Page	**110**
	Book Review	**120**
	Classifieds	**121**



COVER:
Despite the fact that all 50 states and the District of Columbia have child restraint laws in effect, injuries sustained in motor vehicle crashes continue to be the leading cause of death and disability among children. This report provides a comprehensive summary of data on motor vehicle occupant death rates among children aged 0-4 over the past 20 years.

Artwork by Lee Wade of Eminence, KY.

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Avoiding Communication Gaps



J. Gregory Cooper, MD

The reporter from the *Courier-Journal* was asking for my perspective on the recent AMA-Sunbeam debacle. The AMA annual meeting this past December was dominated by this issue in which a contract was approved which allowed the AMA emblem to be attached to Sunbeam health care products. This violation of AMA policy resulted in the dismissal of four AMA staff members and the resignation of the Executive Vice President. The House of Delegates voted to support the policy of the AMA, to review all existing commercial relationships of the organization, and to appoint an investigative committee made up of members of the House.

As an alternate delegate to the AMA, I was able to hear the issue discussed on the floor of the House. The extent of the discussion was limited by the legal issues which have been generated. Detailed information, however, was made available for the delegates and alternates to review privately after receiving background information from an outside attorney involved in the case.

Apart from the strange evolution of this errant venture I was struck by how the organization was making every effort to insure that the representatives of the decision making body of the AMA were fully informed about this explosive issue. Obviously, this was damage control in a time of crisis, but the officers and the Board of Trustees were also trying to re-establish lines of communication which had been battered rather badly. Without open and honest communication between the hierarchy of the AMA and the membership of the House of Delegates there would be no chance of dealing successfully with the crisis.

As I attempted to describe this process to the reporter, I realized that this attempt to maintain lines of communication between the leadership and the members of the House was reflective of the ongoing concern that any organization should have regarding contact with its individual members.

In dealing with this crisis the AMA board and officers had a different perspective on the issues from the members of the House of Delegates. In fact, the House of Delegates appropriately voted to help realign the perspective of the officers and the board! Information had been transferred to the members and they gave their response. The divisive issue was on its way toward resolution.

It doesn't take a Sunbeam crisis to cause an information/confidence gap between various levels of organized medicine. As an alternate delegate I must try to communicate House of Delegate issues back to the KMA members and Kentucky physicians that I represent. The officers and board of trustees of the KMA must keep the members of the KMA informed about the evolution of issues that impact medicine. Those of us that serve as representatives to the KMA House of Delegates have to try to translate the actions of that body to the practicing physicians out in the state.

Physicians who are involved in the process of policy making come to understand the concepts which rule that process. There are rules of order for policy making bodies. There are constraints and parameters that exist in order to avoid chaos and anarchy. There is give and take in the process. There is negotiation, diplomacy, exchange and compromise. In establishing and maintaining order in the process we often find that the results are much slower in coming than we would prefer.

As physicians we seek the truth. When we see it ahead of us we want to excise immediately any obstacles that stand in our way. Patience is often not our strong suit in problem solving. Thus, the practicing physician is often frustrated by the circuitous route that defines policy making. Thus, we may be reluctant to join and support the organizations which determine medical policy.

Those of us who are active in organized medicine have a responsibility to maintain lines of communication with our colleagues. We must let them know that we are dedicated to shepherding the interests of medicine through the maze that is politics.

J. Gregory Cooper, MD
Chair, KMA Board of Trustees

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1998 KMA Legislative Seminar Attracts Overflow Crowd

KMA's biennial Legislative Seminar continues to be a resounding success. Several in an overflow, record-breaking crowd had to stand during the Seminar held in Frankfort on January 28. Those in attendance were eager to hear the latest on major issues of significance facing the medical community in the Commonwealth of Kentucky, and they were not disappointed.

Featured speakers were Lt Governor Steve Henry, MD; Dan Kelly, Senator/Senate Minority Floor Leader; Jody Richards, Representative/ Speaker of the House; George Nichols, Commissioner of the Department of Insurance; Bob DeWeese, MD, Representative; William Monnig, MD, KEMPAC Chair; Wally O. Montgomery, MD, Chair, Committee on State Legislative Activities; Angie DeWeese, Vice President, KMA Alliance; and John Morse, Secretary of the Cabinet for Health Services.

KMA's President Ken Peters, MD, President-Elect Don Stephens, MD, Secretary-Treasurer Bill VonderHaar, MD, and Board of Trustees Chair Greg Cooper, MD, presided.

Following the seminar, many of the attendees visited the Capitol and met with their Legislators to discuss issues of concern to Kentucky physicians. While KMA leadership and staff routinely meet with Legislators to represent your interests, nothing is more effective than communication from a constituent—YOU! Your participation and involvement in the legislative process are ESSENTIAL.

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L-R: Lt Governor Steve Henry, MD, and Commissioner, Department of Insurance, George Nichols.







L-R: Senator/Senate Minority Floor Leader Dan Kelly; Representative/ Speaker of the House Jody Richards; KMA Alliance Vice President Angie DeWeese.





Left: J. Gregory Cooper, MD, Chair, KMA Board of Trustees (L), is pictured with James R. Bean, MD, of Lexington. Above: Fayette County President John R. White, MD, and Fayette County Executive Vice President/CEO Carolyn Kurz.







Left: Wally O. Montgomery, MD, KMA Chair, Committee on State Legislative Activities (center), and his wife Gerry discuss the issues with John Cooper, KMA Legislative Consultant, and Don Chasteen, KMA's Director, Public and Governmental Relations (in background). Above, L-R: President-Elect Donald R. Stephens, MD, and Secretary-Treasurer William P. VonderHaar, MD.



KMAA President Aroona Dave (L) is pictured with Immediate Past President Ruth Ryan.



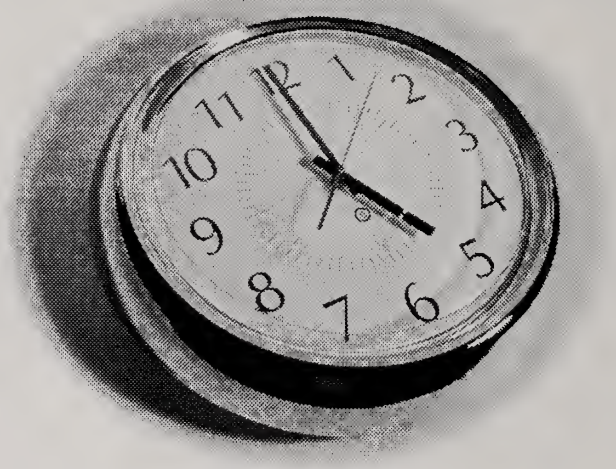
KEMPAC Chair William B. Monnig, MD (L), relaxed with KMA colleagues.





Above: KMA President C. Kenneth Peters, MD, talked with Representative Bob DeWeese, MD. Left: Dr Peters is pictured in a discussion with a colleague.

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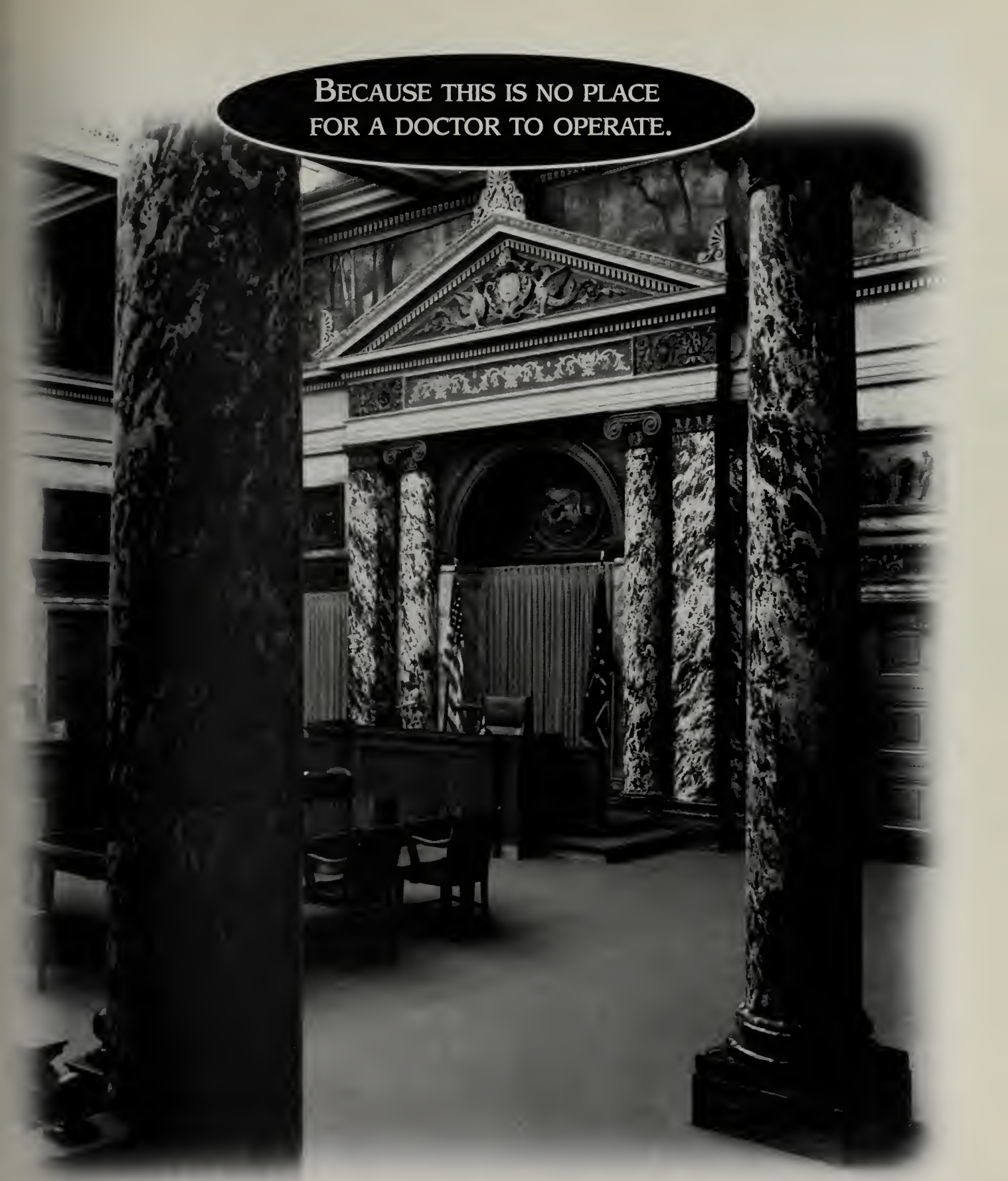
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Kentucky's Child Restraint Law Has Saved Lives:

A 20-Year Review of Fatalities Among Children (Aged 0-4) as Motor Vehicle Occupants

L.A. Goldstein, PhD; C.W. Spurlock, PhD

In 1995, 616 children under 5 years of age died as occupants in motor vehicle crashes (MVCs) in the United States. Of these 616 fatalities, an estimated 328 (57%) children were completely unrestrained in any kind of child restraint device (CRD).[1] Thus, despite the fact that all 50 states and the District of Columbia have child restraint laws in effect,[1] injuries sustained in MVCs continue to be the leading cause of death and disability among children.[2]

Likewise, one of the leading causes of death and disability among Kentucky children aged 0-4 is motor vehicle occupant injuries. In an effort to reduce the number of children killed or injured as MV occupants, Kentucky passed a law (KRS 189.125) in 1982 requiring that, "any parent or legal guardian of a child, forty inches (40˝) in height or less, when transporting his child . . . shall have such child properly secured in a child restraint system of a type meeting federal motor vehicle safety standards."[3]

This report provides a comprehensive summary of data on MV occupant death rates among children aged 0-4 over the past 20 years. An initial report published in 1985[4] presented child fatality data for 1970 through 1984, spanning time periods both before and after enactment of the child restraint law. The current report presents similar data obtained since 1984. The report also describes apparent trends in MV occupant death rates among children aged 0-4, discusses the possible long term effects of the child restraint law, and suggests other factors that may influence restraint usage rates.

Annual totals for the number of deaths among children aged 0-4 as MV occupants were obtained from the Kentucky Department for Public Health, Division of State and Local Health Administration, Vital Statistics Branch. Death rates were calculated per year based on population estimates derived by the Urban Institute at the University of Louisville. The death rates graphed in Fig 1 represent 3-year running averages of the annual death rates presented in Table 1.

From the Kentucky Injury Prevention and Research Center. Correspondence to Dr L.A. Goldstein, Kentucky Injury Prevention and Research Center, 333 Waller Avenue, Suite 202, Lexington, KY 40504-2915, (606) 257-6711 FAX (606) 257-3909, lagold@pop.uky.edu

Table 1. Deaths and Death Rates to MV Occupants Aged 0-4 Before and After Enactment of Child Restraint Law in Kentucky

7-Year Period *Prior* to Child Restraint Law				7-Year Period *Following* Child Restraint Law				Past 5-Year Period			
Year	Fatalities*	Population†	Death Rate	Year	Fatalities	Population	Death Rate	Year	Fatalities	Population	Death Rate
1975	21	276,000	7.6	1983	14	281,000	5.0	1990	9	255,000	3.5
1976	13	271,000	4.8	1984	6	277,000	2.2	1991	18	254,000	7.1
1977	18	272,000	6.6	1985	10	271,000	3.7	1992	5	258,000	1.9
1978	16	276,000	5.8	1986	10	264,000	3.8	1993	11	260,000	4.2
1979	11	281,000	3.9	1987	14	258,000	5.4	1994	8	261,000	3.1
1980	16	283,000	5.7	1988	11	253,000	4.3	1995	14	266,000	5.3
1981	23	285,000	8.1	1989	10	252,000	4.0				
Total	118	—	—	Total	75	—	—	Total	65	—	—
Mean	16.9	277,714	6.1	Mean	10.7	265,143	4.1	Mean	10.8	259,000	4.2

*Kentucky Department for Health Services, Division of Vital Statistics. †University of Louisville, Urban Studies Institute.

Evidence that Child Restraint Use Reduces the Number of Fatal and Nonfatal Injuries

Tennessee led the nation by passing the first child restraint law in 1978. Other states shortly followed suit, and by 1985, every state and the District of Columbia had passed child restraint legislation.[5] That legislative efforts increase the use of CRDs and that CRD usage is effective in reducing the number of deaths and injuries from MVCs are well documented. For example, between 1978 and 1983, child restraint use in Tennessee rose from 8% to more than 30%, and the number of deaths among children younger than 4 years of age

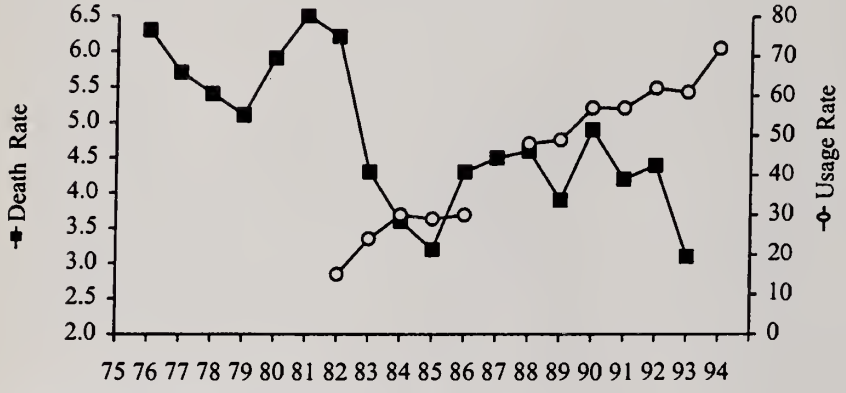


Fig 1 — Motor Vehicle Crash Fatalities vs Restraint Usage Passengers Aged 0-4

declined by more than 50%.[6] In Michigan, the use of CRDs among children aged 0-4 increased from 12% to 51% and the number of injuries to the head and extremities declined 20% to 25%.[7] National averages indicate that the proper use of CRDs can reduce fatalities by 71% and hospitalizations by 67%.[5]

Based on Kentucky data from 1990 to 1994, CRD use was associated with substantial reductions in the number and percentage of children aged 3 and younger sustaining MVC-related injuries. Comparisons of children who were restrained (child safety seat or safety belt) with those who were unrestrained revealed a 50% decline in fatalities for children in restraints. Likewise, there was a 70%, 58%, and 42% reduction in the "incapacitating," "non-incapacitating," and "possible" injury categories, respectively.[8]

Table 2. Deaths to MV Occupants Aged 0-4: Observed vs. Expected Deaths, 1982-1994

Year	Observed Deaths	Expected Deaths*	O/E Ratio†
1982	16	17.3	0.92
1983	14	17.1	0.82
1984	6	16.9	0.36
1985	10	16.5	0.61
1986	10	16.1	0.62
1987	14	15.7	0.89
1988	11	15.4	0.71
1989	10	15.4	0.65
1990	9	15.6	0.58
1991	18	15.5	1.16
1992	5	15.7	0.32
1993	11	15.9	0.69
1994	8	15.9	0.50
1982-1994	142	209.0	0.68

*Average death rate for 1975-81 × population aged 0-4.
†Ratio of observed deaths to expected deaths.

MV Occupant Death Rates Before and After Enactment of Kentucky's Child Restraint Law

During the 7-year period (1975-1981) prior to the passage of the child restraint law in Kentucky, 118 children aged 0-4 died as MV occupants.[2] In 1981, the death rate was 8.1 per 100,000 (0-4 year-olds). In 1983, after passage of the law, the MV occupant death rate among children 0-4 years of age was 5.0 per 100,000. By 1984 (the third year the restraint law was in effect), the death rate was as low as 2.2 per 100,000 (Table 1). This represents a 73% reduction in death rate, and an estimated 17 young lives saved. On average, comparison of the 7-year "before" (1975-1981) period with the 7-year "after" (1983-1989) period revealed a 37% and 33% reduction in the average number of deaths and death rate (respectively) among children aged 0-4 as MV occupants (Table 1). Three-year running averages of death rates among children 0-4 years of age are shown in Fig 1 for 1975 through 1994.

In Table 2, the observed deaths for each year following enactment of Kentucky's child restraint law were compared with the expected number of deaths based on the average death rate prior to passage of the restraint law (1975-1981). Based on a chi-square test, the observed number of deaths were significantly fewer than the expected number of deaths ($p < 0.002$). The results indicate significant reductions in the number of deaths to MV occupants aged 0-4 after enactment of the child

restraint law in Kentucky. While we cannot attribute this reduction entirely to the child restraint law, its enactment certainly facilitated awareness of the importance of CRD use and interventions that contributed to the decline in death rate. Across the Commonwealth, a number of public health, public protection, and local hospital efforts were initiated to educate residents about correct CRD use and to increase the availability of CRDs among lower income families. National trends related to increased acceptance and use of CRDs may also have contributed to the decrease. Thus, combined legislative, educational, and promotional efforts resulted in the observed reduction in child MV occupant deaths in Kentucky.

Trends in MV Occupant Death Rates During the Past 20 Years

To examine trends in the MV occupant death rate of 0-4 year-olds over time, the data in Table 1 have been put into graphic format (Fig 1). Dramatic fluctuations in death rate (*filled boxes*) are apparent, and a number of influential factors could contribute to these changes. For example, what might account for the decrease in MV occupant death rate that occurred between 1975 and 1979? Given Tennessee's geographic proximity to Kentucky, the publicity surrounding Tennessee's law in 1978 may have launched an increase in safety seat use in Kentucky, leading to a subsequent decline in MV occupant death rate among 0-4 year-olds. The decline in MV occupant death rate among young children aged 0-4 was transient; between 1979 and 1981 there was an equally dramatic increase in death rate. Unfortunately, data on the use of child restraints prior to 1982 are not available, and without information on use rates, it is difficult to determine what may have been responsible for the rise in death rate (but see below). However, as predicted, the death rate for MV occupants aged 0-4 declined precipitously after amendment of the Kentucky statute in 1982.

Child Restraint Usage Rates in Kentucky

An observational survey conducted prior to enactment of the law (May and June 1982) reported a statewide child safety seat usage rate (Fig 1, *open circles*) of 14.4%.[9] An identical survey performed after the law became effective (May through August 1983) reported a usage rate of 22.7%.[10] Although usage rates leveled off between 1984 and 1986, a steady increase has been reported since 1988. (An observational survey was not performed in 1987). In 1994, a statewide child restraint usage rate of 72% was reported. The usage rate among children less than 1 year of age was 83%; for children aged 1 to 3, the usage rate was 68%.[11] If usage rates continue to increase, the state will meet the *Healthy Kentuckians 2000* objective to increase the use of child restraint systems among children aged 0-4 to at least 75%.[12] Nationally, child restraint use in 1994 was estimated at about 88% for children under 1 year of age, and 61% for children 1-4 years of age.[13]

Possible Factors that Influence Childhood MVC-Related Fatality Rates

That the use of restraint systems is effective in reducing the number of deaths and injuries from MVCs is well documented. It is also apparent that legislative efforts increase restraint usage.[5-8] Nevertheless, additional factors can affect usage rates, and events that occurred subsequent to enactment of the child restraint law may have impacted MV occupant death rates among children aged 0-4 in Kentucky. For example, in 1988 the state introduced a penalty ($50 fine) for violation of the restraint law.[11] To the extent that this sanction was enforced, the penalty may have contributed to the observed increase in usage. While information on the number of citations for such violations was not available, there was a small decline in MV occupant death rate between 1988 and 1989 (Fig 1).

In 1990, Lexington enacted a local ordinance mandating the use of seat belts for adults; the city of Louisville passed a similar ordinance in 1991. By 1994, all city and county ordinances were replaced by a statewide safety belt law.[11] During this time, there was a steady increase in safety seat usage for children under 4 years of age from 57% in 1990, to 72% in 1994.[11] The societal impact of these legislative actions on related safety issues should not be underestimated. For example, adult and child occupant restraint use is higher in states with a mandatory safety belt law than it is in states without such a law.[14]

We wanted to examine the relationship between statewide highway safety campaigns and childhood MV occupant death rate during this 20-year period. However, the information we received was sparse, and was obtained from a verbal history (Kentucky State Police, personal communication) rather than from official records. Other historically relevant events (eg, bus crashes, multiple-vehicle/fatality crashes) may affect the

number of fatalities (eg, 18 children killed in 1991; Table 2) and hence, MV occupant death rate during any given year.

Limitations

It is important to keep in mind that the relationships we have discussed in terms of the child restraint law and death rates among MV occupants aged 0-4 are strictly correlational, as are the relationships between death rates and CRD use rates. For example, for the data used to derive MV occupant death rates, restraint status information is not available. Similarly, it is not feasible to obtain information on subsequent MVC involvement and/or injury outcomes from the observational studies conducted to procure information on restraint status. As discussed above, many factors potentially impact both the occurrence of MV occupant injuries and CRD use. To develop appropriate injury prevention strategies, all factors must be considered and interpreted based on their historical and sociopolitical context.

Conclusion

The data provided in this 20-year review suggest that passage of the child restraint law in Kentucky contributed, at least in part, to reductions in the death rate among children aged 0-4 as MV occupants. However, despite improvements in CRD usage and MV occupant death rates, MVC involvement continues to be a leading cause of death and disability among children in Kentucky and across the United States. A large number of children remain unrestrained, or improperly restrained, as MV occupants. It is imperative that efforts to promote CRD use continue unabated. CRDs must become more readily available and affordable, and purchasers must be educated in the proper installation of the CRD, as well as proper placement of the child in the CRD. By promoting *universal* and *proper* use of CRDs, unnecessary deaths and injuries to children as MV occupants can be significantly reduced.

References

1. Traffic Safety Facts, 1995 — *Occupant Protection.* Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1996.
2. Traffic Safety Facts, 1995 — *Children.* Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1996.
3. Kentucky Revised Statute, Chapter 189, Section 125 (KRS 198.125). Frankfort, KY: Legislative Research Commission.
4. Spurlock CW. Motor vehicle passenger deaths among Kentucky children age 0-4. *Kentucky Epidemiologic Notes and Reports.* 1985;20:3-4.
5. Kahane CJ. An evaluation of child passenger safety: The effectiveness and benefits of safety seats. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1986; Report No. DOT-HS-806-890.
6. Decker MD, Dewey MJ, Hutcheson RH, Schaffner W. The use and efficacy of child restraint devices. *JAMA.* 1984;252:2571-2575.
7. Margolis LH, Wagenaar AC, Liu W. The effects of a mandatory child restraint law on injuries requiring hospitalization. *Am J Dis Child.* 1988;142:1099-1103.
8. Agent KR, Pigman JG. Analysis of traffic accident data in Kentucky (1990-1994). Kentucky Transportation Center, 1995; Research Report No. KTC-95-19.
9. Agent KR, Crabtree JD. Child restraint usage in Kentucky (pre-legislation). Lexington, KY: Kentucky Transportation Research Program, 1982; Research Report No. UKTRP-82-15.
10. Agent KR. Child safety seat usage in Kentucky after enactment of a mandatory usage law. Lexington, KY: Kentucky Transportation Research Program, 1983; Research Report No. UKTRP-83-18.
11. Agent KR. 1994 safety belt usage survey and evaluation of effectiveness in Kentucky. Lexington, KY: Kentucky Transportation Center, 1994; Research Report No. KTC-94-19.
12. Kentucky Department for Health Services. *Healthy Kentuckians 2000.* Frankfort, KY: Cabinet for Human Resources, Department for Health Services, 1991.
13. National Center for Statistics and Analysis. National Occupant Protection Use Survey: Controlled Intersection Study. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration. Research Note, May 1995.
14. Russell J, Kresnow M-J, Brackbill R. The effect of adult belt laws and other factors on restraint use for children under age 11. *Accid Anal Prev.* 1994;26:287-295.

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Chronic Cavitary Pulmonary Sporotrichosis: Efficacy of Oral Itraconazole

Jesus Ramirez, MD; Ryland P. Byrd, Jr, MD; Thomas M. Roy, MD

The small number of patients suffering from pulmonary involvement with Sporothrix schenckii *has prevented prospective controlled studies that could determine the optimal therapy for this chronic infection. The clinician's ability to determine the best medical treatment for chronic cavitary pulmonary sporotrichosis is also tempered by the limited use of newer azole antifungal agents in this disorder as well as the relative lack of efficacy reported with older therapies. We present a 50-year-old male with primary pulmonary sporotrichosis whose chronic cavitary disease responded to oral itraconazole.*

Sporothrix schenckii is a dimorphic saprophytic fungus with a worldwide distribution. It can be isolated from soil, plants, moss, and thorny bushes. Pulmonary infection with *Sporothrix schenckii* is rare and occurs by direct inhalation or aspiration of conidia. Involvement of the respiratory system from disseminated lymphocutaneous infection accounts for only 10% of pulmonary disease caused by sporotrichosis.[1] Despite the chronic nature of the pulmonary lesion, treatment is indicated due to the possibility of death and the probability of ongoing lung destruction.

Because the medical management of chronic cavitary sporotrichosis with traditional antifungal agents has been unsatisfactory,[1,2] surgical resection is generally considered the most effective treatment. However, fully one half of patients with pulmonary sporotrichosis have some impairment of host defenses and surgery is not always a realistic option. The introduction of newer antifungal agents, the imidazoles, has offered a unique opportunity to employ daily oral therapy. An earlier case report recounted that itraconazole successfully cured a patient with pulmonary sporotrichosis.[3] We report a second patient with chronic cavitary sporotrichosis who was treated with oral itraconazole and achieved clinical and radiographic cure.

Case Report

A 50-year-old male was referred for evaluation of weight loss, hemoptysis, and a left upper lobe cavity. The left upper lobe cavity had first been noted 3 years previously. No diagnosis had been made despite three bronchoscopic investigations. PPD had been negative on several occasions. He did poorly and suffered a 30 pound weight loss despite intermittent long term treatment with various antibiotics. His hemoptysis began 3 months prior to our evaluation and had progressed to expectoration of approximately 20-40cc of bright red blood per day. He denied nausea, vomiting, diarrhea, shortness of breath, fevers, chills, or night sweats during his illness. He denied having a rash or enlarged and tender lymph nodes. He admitted to no risk factors for human immunodeficiency virus infection (HIV).

His past history was significant for a partial gastrectomy for peptic ulcer disease and chronic obstructive pulmonary disease (COPD) from tobacco use. He had worked for 12 years as a landscaper until he became disabled due to chronic fatigue. He did not use alcohol.

The patient was afebrile and his vital signs were normal. The patient was thin. There was decreased fremitus and increased resonance anteriorly in the left upper lung field. Crackles were present in this area. There was a well healed midline abdominal surgical scar. The remainder of his physical exam with particular attention to the skin and lymph nodes was normal.

The patient had a mild normocytic, normochromic anemia with a hemoglobin and hematocrit of 11.0 g/dl and 33%, respectively. His white blood cell count and differential were normal. His serum biochemical survey and electrolytes were normal. His sedimentation rate was elevated at 79 mm/hr. HIV titer was negative. A PPD was nonreactive. PA and lateral chest radiographs docu-

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Fig 1 — PA chest radiograph documenting a large thick walled cavity in the left upper lobe.

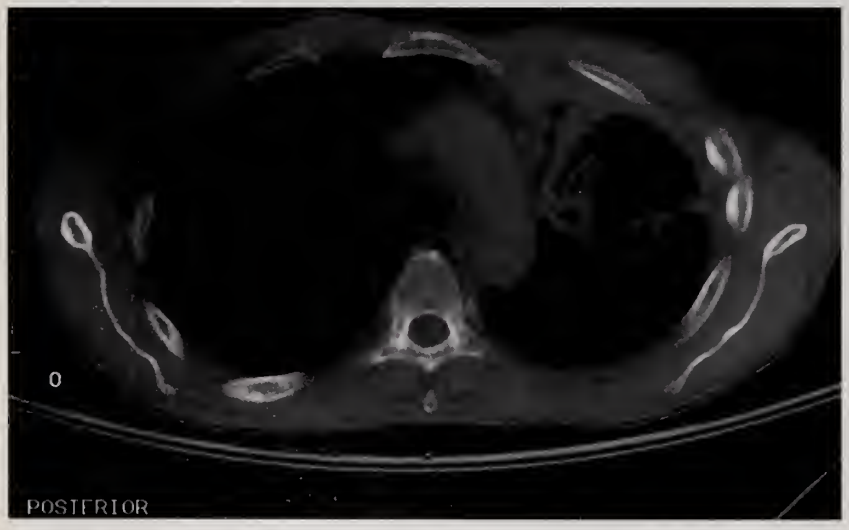


Fig 2 — CT scan of the chest demonstrating a left upper lobe cavity surrounded by an infiltrate.

mented a large thick walled cavity in the left upper lobe (Fig 1). Computerized tomography confirmed the chest roentgenogram findings (Fig 2).

Sporotrichum titer by complement fixation was positive at 1:80 in our infectious disease laboratory and subsequently by our regional reference laboratory. All other fungal serology was negative. The patient refused bronchoscopy and surgery. *Sporothrix schenkii* was cultured from induced sputum.

The patient showed gradual and progressive improvement when oral itraconazole was started at 400 mg/day in divided doses. He gained 20 pounds of weight, his level of energy improved, and his hemoptysis resolved. His hemoglobin increased to 14.1 mg/dl and his sedimentation rate returned to normal. After 1 year of itraconazole, the left upper lobe cavity regressed in size and became thin walled. His sporotrichosis titers returned to normal over 9 months. He completed 12 months of daily therapy without side effects. He has not shown any evidence of relapse in the 12 month period following discontinuation of itraconazole.

Discussion

Primary pulmonary sporotrichosis and pulmonary involvement with systemic infection are rare occurrences with less than 150 reported patients.[3] Almost all of these individuals lived in the United States. Approximately 73% of the patients diagnosed with pulmonary sporotrichosis have resided in the states bordering the Mississippi and Missouri rivers.[1] Patients rarely present before age 30 or after age 60 and the average age of patients with pulmonary sporotrichosis is 46 years. The 6 to 1 male predominance in this disease may reflect a gender bias towards activities or environments where the fungus is aerosolized.[1] Over one half of these patients have some impairment of host defenses such as diabetes mellitus, COPD, and alcoholism.[1-6] Although cutaneous and disseminated sporotrichosis have occurred in patients with the acquired immunodeficiency syndrome (AIDS),[7] pulmonary infection has been rare in this population.[8]

The roentgenographic findings of pulmonary sporotrichosis may include interstitial and nodular infiltrates, consolidation, and tracheobronchial lymphadenopathy,[1-3,6,9] but two thirds of the patients present with an upper lobe cavity that is confined to one lung. These cavities are generally irregular, thin walled and surrounded by an infiltrate.[9] Fluid within the cavity is extremely rare as are pleural effusions.[9] There is a single report of empyema due to sporotrichosis.[10]

Chronic cavitary pulmonary sporotrichosis has not responded well to traditional medical therapy. While SSKI is effective in cutaneous disease and may be effective in non-cavitary pulmonary infection, it is not effective in the treatment of cavitary

pulmonary sporotrichosis having a success rate of only 1 patient out of 14.[1,2] The cure rate of pulmonary sporotrichosis with intravenous amphotericin B ranges from 35% to 50%.[1,2,11] Moreover, *Sporothrix schenckii* organisms have been identified that are resistant to amphotericin B.[5,12]

The newer azole antifungal agents have also failed to successfully treat pulmonary sporotrichosis.[1,3,5] These antifungal agents exhibit fungistatic activity through the inhibition of ergosterol biosynthesis, which is a vital component of fungal cell membranes. Ketoconazole (an imidazole) was the first to become available in the United States but has been found to be the less effective on altering the sterol content of four strains of the fungus *Cryptococcus neoformans* than the triazole, itraconazole.[13] Similar studies have not to our knowledge been preformed on *S schenckii*. Fluconazole has been tried without success in three patients with pulmonary sporotrichosis.[14]

Itraconazole is possibly more effective due to its high lipophilicity and efficient fungal penetration.[13] Cutaneous, lymphangitic, osteoarticular, and non-pulmonary disseminated infections with *S schenckii* have all been effectively treated with itraconazole.[6,15-18] A cure was achieved in one previous patient with chronic cavitary pulmonary sporotrichosis.[3] In another study, three patients with pulmonary sporotrichosis were treated with itraconazole.[4] One patient completely responded to therapy, another relapsed after his initial 18 month course of itraconazole at 400 mg per day, and the third patient failed to respond at all. Unfortunately, the characteristics of the infection and its radiographic findings were not documented in this report and we cannot be sure that a patient with chronic cavitary sporotrichosis was treated.

Based on our patient and the limited data available, oral itraconazole appears to be at least as effective in the treatment of chronic cavitary pulmonary sporotrichosis as intravenous amphotericin B. Importantly, itraconazole has the advantages of an oral route of administration and safer toxicity profile.[15] Individuals with local cavitary pulmonary sporotrichosis who are good surgical candidates should undergo complete surgical resection. The combination of complete surgical resection and amphotericin B has achieved the most favorable results with cure rates of 70% to 80%.[1,2,17]

Resection, however, is not always feasible, especially in patients with COPD and compromised lung function. Oral itraconazole therapy should be considered in this circumstance. Patients who are not surgical candidates might benefit from daily oral itraconazole for 1 to 2 years. Until the efficacy of itraconazole can be tested on additional patients, intravenous amphotericin B should remain the initial therapy for the patient who is seriously ill.[15] In the patient with a more insidious pulmonary disease, itraconazole offers the clinician an alternative to intravenous amphotericin B. The exact dosage and duration of treatment for chronic cavitary sporotrichosis remain to be elucidated.

References

1. Pluss JL, Opal SM. Pulmonary sporotrichosis: review of treatment and outcome. *Medicine.* 1986;65:143-153.
2. Gerding DN. Treatment of pulmonary sporotrichosis. *Semin Respir Infect.* 1986;1:61- 65.
3. Breeling JL, Weinstein L. Pulmonary sporotrichosis treated with itraconazole. *Chest.* 1993;103:313-314.
4. Sharkey-Mathis PK, Kauffman CA, Graybill JR, et al. Treatment of sporotrichosis with itraconazole. *Am J Med.* 1993;95:279-285.
5. Dall L, Salzman. Treatment of pulmonary sporotrichosis with ketoconazole. *Rev Infect Dis.* 1987;9:795-798.
6. Winn RE, Anderson J, Piper J, et al. Systemic sporotrichosis treated with itraconazole. *Clin Infect Dis.* 1993;17:210-217.
7. Bolao F, Podzamczer D, Ventin M, et al. Efficacy of acute phase and maintenance therapy with itraconazole in an AIDS patient with sporotrichosis. *Eur J Clin Microbiol Infect Dis.* 1994;13:609-612.
8. Heller HM, Fuhrer J. Desseminated sporotrichosis in patients with AIDS: case report and review of the literature. *AIDS.* 1991;5:1243-1246.
9. Rohatgi PK. Pulmonary sporotrichosis. *S Med J.* 1980;73:1611-1617.
10. Fields CL, Ossorio MA, Roy TM. Empyema associated with pulmonary sporotrichosis. *S Med J.* 1989;82:910-913.
11. Parker JD, Sarosi GA, Tosh FE. Treatment of extracutaneous sporotrichosis. *Arch Intern Med.* 1970;125:858-863.
12. Baker JH, Goodpasture HC, Kuhns HR, et al. Fungemia caused by an amphoteracin B-resistant isolate of *Sporothrix schenckii. Arch Pathol Lab Med.* 1989;113:1279-1281.
13. Franzot SP, Hamdan JS. Effects of three azole derivatives on the lipids of different strains of *Cryptococcus neoformans*. *Mycoses.* 1995;38:183-189.
14.Kauffman CA, Pappas PG, McKinsey DS, et al. Treatment of lymphocutaneous and visceral sporotrichosis with fluconazole. *Clin Infect Dis.* 1996;22:46-50.
15. Kauffman CA. Old and new therapies for sporotrichosis. *Clin Infect Dis.* 1995;21:981- 985.
16. Restrepo A, Robledo J, Gomez I, et al. Itraconazole therapy in lymphangitic and cutaneous sporotrichosis. *Arch Dermatol.* 1986;122:413-417.
17. Lavalle P, Suchil P, De Ovando F, et al. Itraconazole for deep mycoses: preliminary experience in Mexico. *Rev Infect Dis.* 1987;9:s64-s70.
18. Borelli DL. A clinical trial of itraconazole in the treatment of deep mycoses and leishmaniasis. *Rev Infect Dis.* 1987;9:s57-s63.

Financial Planning Considerations at Retirement

By Robert J. Cole, Jr, CLU, ChFC, CFP

The process of retirement planning is a difficult one for a physician. The Planning process should address the areas of Investment Planning, Estate Planning, and Risk Management. This article examines each of these dimensions with special emphasis on Modern Portfolio Theory as the basis for investment planning.

Popular Myths

There are several popular myths that many people mistake as accurate. Like all myths, these contain some portion of truth but simplify what is a typically complex issue. A good example of this is "An apple a day keeps the doctor away"; or another one is "If I ignore the pain, it will go away"; and finally, my favorite one is "I can do my own financial planning." The purpose of this article is to address some of the truths that are necessary in order to understand the financial planning steps that need to be taken as one approaches retirement.

The Planning Process

The first step in the process is to estimate your retirement income needs. In order to accomplish this there are four assumptions that have to be made. First, you need to estimate your current standard of living or said another way, how much money do you spend each month now and what adjustments do you feel will be made after you retire? Second, what rate of return will you earn on your investment assets? Third, what is the inflation assumption? And, finally, what is the life expectancy of the parties involved? It is critically important that you give sound thought to these four assumptions. There are many popular software programs that will make retirement calculations, but, without an accurate accounting of each of these assumptions, the output of these programs is fairly meaningless.

Certainly one of the most important components of this process is a full scale review of your investment plan. This involves taking a strict inventory of your current *working assets.* By working assets we mean assets that can produce revenue for you to live on during your lifetime. Typical sources of these assets are retirement plans and individual investments.

Risk Assessment

Once this accounting is completed, it is necessary for you to assess your risk tolerance. This is a fairly complicated procedure and myths abound in this area. Risk is an interesting concept. Most people feel that risk means losing your principal. However, it is clear with today's long lifestyles that the real risk is not *losing* your principal but *outliving* your principal. Many people use antiquated guidelines for developing the risk level in their portfolio based on past experience, which in many cases no longer applies in today's environment. There are several risk assessment tools available today. Table 1 shows a simple approach. By totaling your preferences you can decide how to allocate your assets among the three basic asset classes, Money Market, Fixed Income, and Equities.

One of the most accepted approaches to risk management is called Modern Portfolio Theory. This is the philosophy set forth by Harry Markowitz in the late 50s. Under this approach, a person assesses their risk tolerance (as measured by the standard deviation) for various asset classes, then combines these classes in a mathematically constructed model designed to maximize the return while minimizing the fluctuation. Fig 1 shows the risk and return history of several basic asset classes over the last 20 years. As you can see, there is a direct relationship between the amount of risk involved and the rate of return that you earn. The question is how much to put in each asset class? This is where portfolio optimization can assist you.

Table 1. The Portfolio Allocation Scoring System (PASS)

Investment Objective	Most	Very	Some	Little	None	Total Score	Money market/Fixed income/Equities
1. High long-term total return	5	4	3	2	1	35	5/5/90
2. Long-term capital gains potential	5	4	3	2	1	29-34	10/10/80
3. Tax advantages	5	4	3	2	1	23-28	20/20/60
4. High current income	1	2	3	4	5	17-22	30/30/40
5. Low total return fluctuation	1	2	3	4	5	11-16	40/40/20
6. Low single-period loss probability	1	2	3	4	5	7-10	50/40/10
7. High degree of liquidity	1	2	3	4	5		

Portfolio Optimization

The concept of portfolio optimization uses computer prototypes to develop a model that is most likely to produce the rate of return for the stated risk level that you are willing to take. The beauty of this particular approach is its simplicity. Once the proper percentages have been established, the model produces several statistical guidelines for the selection of the underlying investments. The common way to implement this approach is to use mutual funds. By carefully selecting the mutual funds that meet the statistical criteria developed for each asset class in the model, you can increase the probability that you will meet your target rate of return. Another advantage under this approach is that one can ignore the requirements that individual stocks impose on an investment program, namely timing. You let the mutual fund manager make those decisions and simply track his or her performance. The typical holding period for this asset allocation model is 5 years.

Annual Reallocation

Once these steps are completed, it is only necessary once a year to take a look at your current portfolio and see how the percentages of the portfolio compare to your target percentages. If a certain sector of the portfolio has grown by more than 5% it is imperative to sell assets in that class and redistribute the funds amongst the other asset classes until you return to your original asset allocation model. This process preserves the risk level set in the prototype. We prefer the use of no-load funds since they minimize the transaction costs involved in annual reallocation. You should also evaluate each fund's relative performance and investment style to assure that you still have the best possible choice.

Pension Assets

Another critical decision that faces the physician at retirement is how to take distributions from his retirement plans. This is a very complicated field and yet many people approach the decision process rather casually. When you consider the fact that this is normally the largest single asset in

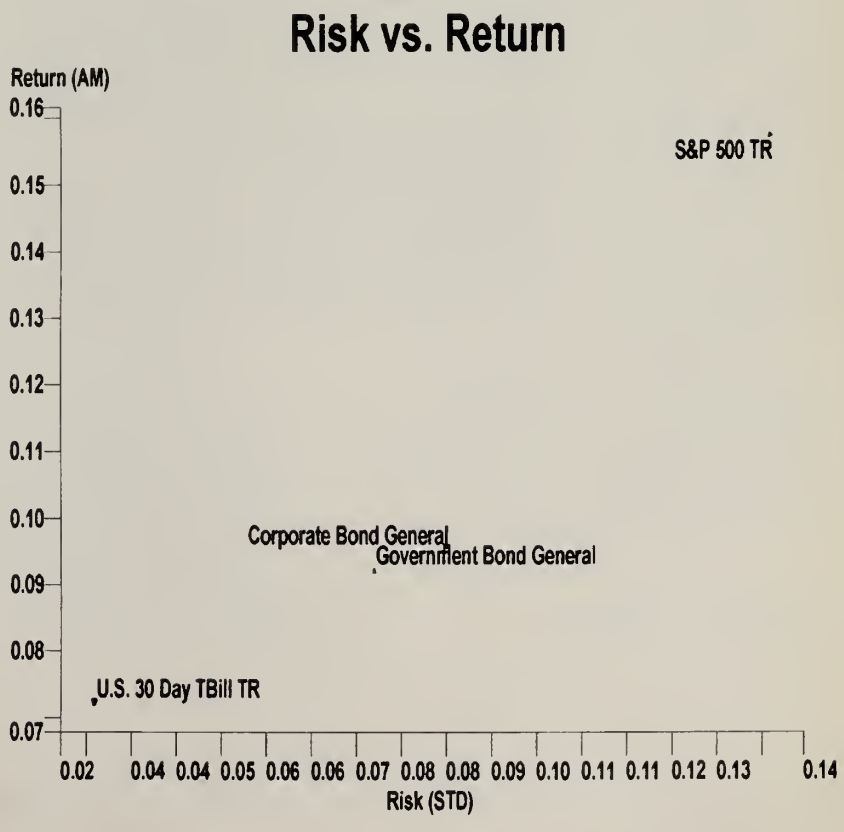


Fig 1

your estate, it would make sense that there should be some planning done *before* the distribution is required. Taxes, both income and estate, play a major role in this decision process.

The first decision is whether to take a direct rollover to an IRA or to take a lump-sum distribution and take advantage of special averaging rules. IRAs are taxed differently than qualified retirement plans, and as such, careful consideration should be given not only to the needs of the retiree but also to the needs of the beneficiaries *before* a particular approach is selected. Minimum distributions (which are required around the age of 70½) add a third dimension to this confusing process. There are three methods for calculating minimum distributions and each of them have considerable financial planning consequences, both in the income tax area and in the investment area. The selection of the proper one requires a review of *all* the planning objectives, not just the investment goals.

Risk Management Considerations

It is normally at retirement that one makes several final decisions concerning their insurance coverages. This involves both medical insurance and life insurance. A careful review of one's estate objectives should give an indication as to how these insurance coverages fit into one's overall plan. It may be time to consider a life insurance trust. Finally, one should review their current wills and trusts to see if any changes are necessary in light of the movement into the retirement phase.

If you retire before eligibility for Medicare and are currently covered under a group plan, COBRA may offer an opportunity to meet your medical insurance needs. Once you become eligible for Medicare, a good Medicare supplement policy is advisable. Typically long-term care coverage (nursing home insurance) is an issue if your estate is less than $4 million. Because of the many different options that are available under these plans, it is necessary to take a studied look before making a decision.

Summary

Retirement can be an emotionally difficult transition. Because one makes choices during this period of time that could affect the balance of his or her lifetime, it is important that one carefully consider each of the components of their financial picture in order to make the best possible decision. Because of the magnitude of the retirement decisions, it is imperative that each of these decisions is integrated so that an overall plan can be developed and used as a guideline for the balance of one's life. After all this is completed, one should be able to look forward to a fruitful and enjoyable retirement period that he or she has worked so hard to accomplish.

The above article has been summarized from a presentation given by Mr Cole at the Kentucky Medical Association Seminar "Gearing Up for Retirement," presented in April of 1997. Mr Cole is president of Financial Architects, Inc, a fee-based financial planning firm.

Telemedicine

"Our professors and predecessors showed us how laying on of the hand, touching and listening, were paramount talents, and that clinical judgement came with experiencing the intimate doctor-patient relationship. How do we equate this style of medicine with the next generation of electronic wizardry?"

Telemedicine is here, the tools for its implementation are evolving, and now we must consider the side effects. Have a telephone, even with basic service, and the information will start to flow with ease. Better with a modem, connect to the Internet or directly to the source, and let the downloading begin. Face the television, monitor to the computer literate, and the visual conduction comes through with colorful impact. Add the microphone, some fair speakers, and the only thing missing is the initial palpable handshake, since the mere connection in computer lingo is an electronic handshake.

Now comes the rub. What are the rules, who makes them, and who can enter the playing field? My latest Kentucky Licensure Board minutes detail some work already, with committee and personnel being appointed and charged with deciding the qualifications. Determining credentials can be burdensome for those sitting in judgement of those who want to practice telemedicine, since little information is available about exactly what and where this will take place. These frontiersmen in medicine can be pioneers, pathfinders who invent and construct the road that others will follow. Some may not be wholly benevolent, seeing financial and entrepreneurial possibilities, instead of purely making progress. Our professors and predecessors showed us how laying on of the hand, touching and listening, were paramount talents, and that clinical judgement came with experiencing the intimate doctor-patient relationship. How do we equate this style of medicine with the next generation of electronic wizardry?

Is it for the patient's welfare? This basic question, along with "Do no harm!" should be a guide. Those of us asked to evaluate whether a new service, or some practitioner using these tools, should be accepted, have to bear in mind those questions and demands. As telemedicine impacts our practices and patients experience what has taken place, we should carefully document these results and forward this information to the proper authorities. The appropriate state and national boards, traditionally watching what their members do and desire, would also be good references.

Progress should be encouraged, but considered for what it brings and leaves behind. Our medicine will never be the same, and we do not want it to be. We do want our medicine to be better, and that should be the goal of telemedicine as well.

Stephen Z. Smith, MD



Aroona Dave

Kentucky Medical Association Alliance

This year our 75th Annual Convention is very special because members of the Hopkins County Medical Alliance are working diligently to make it very enjoyable and memorable for all of you.

This is our 75th Annual Convention. We will be installing our 74th President, Jan Crase (Mrs James) and entering the 76th year. You say, "Hey, these numbers don't match!" Well, I agree, but our first President, Mrs Graham Laurence, and second President, Mrs Van Albert Stiley (May) served two years each in a row.

They served the Alliance in dignity, integrity, and great pride. I applaud them and all those Presidents who came before me.

Annual Convention is the time when we reward ourselves for all the accomplishments of the year. It is a forum to address Amendments to our Bylaws/Policies that will help our future leaders implement them and run the organizational affairs smoothly.

It is the time to take a stand on current health issue legislation by adopting resolutions. It is the time for networking with others across the state, a time to rekindle old friendships, and for rejoicing our 75 years of Excellence.

We are the Proactive Volunteer Voice of Kentucky Medical Association. It also happens during this month when doctors across the states and nation are being honored. Their excellence in health care delivery to children and to the families is being celebrated in many ways on March 30, 1998. March is also Medical Alliance Month, during which we reflect upon all our Projects/Programs.

So, I personally welcome you to the Celebration of 75 Years of Kentucky Medical Association, Alliance's Annual Convention:

April 20-22, 1998
(Monday-Wednesday)
at Day's Inn
1900 Lantaff Boulevard
Madisonville, KY 42431
Telephone: 502-821-8620
Fax: 502-825-9282
(Day's Inn is located at Exit 44, Pennyrile Parkway)

Advance Reservations are required and highly recommended for ALL MEMBERS!

For complete reservation for the Hotel and Convention Registration, please look for *Blue Grass News* coming to you soon.

Please come and join us.

Fondly,

Aroona

Aroona Dave
KMAA President

DAY'S INN — MADISONVILLE

Sunday, April 19

6:00-9:00 PM Hospitality Suite

Monday, April 20 (Day's Inn)

7:30 AM-5:00 PM Hospitality
8:00 AM-4:00 PM Registration
9:00 AM-12:00 NOON Basket Silent Auction
9:00 AM-12:00 NOON Committee Meetings
12:00 NOON-1:00 PM LUNCHEON & HOSPITALITY
2:00-3:00 PM TRANSITION FOR OFFICERS/CHAIRMEN
3:00-4:00 PM Pre-Convention Board Meeting
5:30 PM RECEPTION & DINNER (to honor 1997-98 Board of Directors & County Presidents-Elect)
At the home of Dr & Mrs James Donley,
520 Logo Drive, Madisonville, KY 42431

AT HEALTH TECHNOLOGY CENTER — MADISONVILLE

7:30 AM-9:00 PM MEDIA VIOLENCE
(CME/Staff Development Credit Available)
Dr David Walsh*
Delegates & Guests
Area Health Coordinators

Tuesday, April 21 (Day's Inn)

Basket Silent Auction continues
7:00 AM Hospitality
7:00-8:00 AM Registration
8:00-11:30 AM House of Delegates
11:30-1:00 PM Past Presidents Luncheon
Special Presentations
75th Anniversary
1:00-4:00 PM Tour of Adsmore, Princeton, KY
6:00 PM Reception at **The Loft** for
President-Elect, Jan Crase (James)
and 1998-1999 Board
6:30 PM Dinner, Installation of Officers, Entertainment,
celebration of 75th Birthday
9:00-10:30 PM Hospitality

Wednesday, April 22 (Day's Inn)

8:30 AM Continental Breakfast
Post Convention Board Meeting

**Dr Walsh is the president and founder of the National Institute on Media and the Family. In keynote speeches throughout the United States, as author of* Selling Out America's Children *(Fairview Press, 1994) and the American Medical Association's* Physician Guide to Media Violence *(AMA, 1996), and as the leader of hundreds of community discussions, Dr Walsh has gathered together the forces of many diverse organizations and spawned a vigorous national dialogue on the issue of violence in the media.*

1997-98 New Officers' Profiles

During the 1997 KMA Annual House of Delegates meeting held in Louisville, three new officers were elected to serve on the Board of Trustees. KMA congratulates these members on their election and thanks them for their valuable leadership.



Robert C. Hughes, MD
First District Trustee

A board certified family physician practicing in Murray, Dr Hughes was elected to serve a 3-year term as First District Trustee.

Dr Hughes began his long association with KMA while in medical school by serving on KMA's Emergency Medicine Committee and the Committee to Investigate Changing Trends in Medicine. During that time, he also helped organize the original Resident's Physician Section of KMA. An active KMA member since 1983, Dr Hughes served several terms as a KMA Delegate and as an Alternate First District Trustee in 1996-97. Current obligations include the KEMPAC Board, Medicaid Managed Care and State Legislative Activities Committees. Professional affiliations include American Academy of Family Physicians and the Southern Medical Association. He has been a member of the Calloway County Board of Health since 1984, Chairman of the Department of Medicine at Murray-Calloway County Hospital since 1993, and has served as a volunteer Assistant Clinical Professor at both the University of Louisville and University of Kentucky medical schools since 1989.

A native of Martin, Kentucky, Dr Hughes, 42, completed his bachelor's degree at Transylvania University in 1977 and earned his MD from U of L in 1981. Following an internship in the Department of Obstetrics and Gynecology at U of L, he completed a residency in Family Practice in 1984.

Dr Hughes is married to Joyce Marie Hughes, MD, a pediatrician, and they are the parents of four sons. His personal interests and hobbies include hunting, politics, and reading.



John M. Patterson, MD
Seventh District Trustee

A board certified urologist in private practice in Frankfort, Dr Patterson was elected to serve a 3-year term as Seventh District Trustee.

An active member of KMA since 1987, he has served continuously as a KMA Delegate from Franklin County since 1992 and served as an Alternate Delegate in 1995-97. Dr Patterson's current service includes membership on the Cancer Committee and KMA Membership Task Force Committee. He is a past president of the Franklin County Medical Society, diplomate of the National Board of Medical Examiners, Federal Aviation Medical Examiner, and a fellow of the American College of Surgeons. Dr Patterson has authored several clinical publications. In addition to his many contributions to organized medicine, he also finds time to be involved in several community and civic organizations.

Dr Patterson, 40, earned his undergraduate degree in 1979 and medical degree in 1983 from the University of Kentucky College of Medicine. He continued his medical education at the University of Kentucky by completing a surgery internship in 1984 and a urology residency in 1988.

He is married to Ann Irvine Pollock, MD, an internist. They have one daughter and two sons, and make their home in Frankfort. Dr Patterson's hobbies include restoring and flying airplanes.



Andrew R. Pulito, MD
Tenth District Trustee

A board-certified Lexington surgeon, Dr Pulito was elected to serve a 3-year term as Tenth District Trustee.

An involved member of KMA since 1979, Dr Pulito served as a KMA Delegate from 1988 to 1994 and as an Alternate 10th District Trustee in 1995-97. He has served on numerous KMA committees in the past, and current obligations include service on the KEMPAC Board of Directors, Membership Task Force Committee, and the State Legislative Activities Committee. Dr Pulito, a past president of the Fayette County Medical Society, is extensively involved in several professional and civic organizations including the Surgical Section and Bioethics Section of the American Academy of Pediatrics, fellowship in the American College of Surgeons, and as a member of the Education Committee of the American Pediatric Surgical Association. He is a Professor of Surgery and Chief, Division of Pediatric Surgery, and Vice-Chairman of the Department of Surgery at the University of Kentucky College of Medicine.

A native of New York City, Dr Pulito, 54, earned his undergraduate degree at Holy Cross College in 1965 and MD from Columbia University in 1969. He completed an internship in 1970 and a residency in surgery in 1974 at the University of Virginia Hospital. Dr Pulito subsequently completed a residency in pediatric surgery at Babies Hospital, Columbia-Presbyterian Medical Center in 1976.

Residents of Lexington, Dr Pulito and his wife, Evelyn, are the parents of a son and daughter.

Highlights of AMA House of Delegates 1997 Interim Meeting

Previously, each member of the Kentucky Delegation to the American Medical Association presented a written report on a single reference committee in each month succeeding the meeting of the AMA House of Delegates. To make the material considered by the House more timely, this report is being given which provides highlights of all reference committee actions. This information is submitted through the resources of the Kentucky Delegation.

—Donald C. Barton, MD
Senior AMA Delegate

Reference Committee on Constitution and Bylaws

- The House of Delegates accepted a Council on Ethical and Judicial Affairs (CEJA) recommendation that physicians not sell non-health related goods from their offices or other treatment settings, with minor exceptions relating to sale of low costs products as part of community fund raising efforts.
- The House also accepted CEJA recommendations on financial incentives in the practice of medicine that reaffirm the physician's primary obligation to the individual patient and that this obligation must override reimbursement considerations. Physicians, individually or through representatives, should evaluate financial incentives prior to entering into any contracts to ensure that quality is not compromised. Patients must be informed by health plans of financial incentives that could affect their level of care and physicians must be prepared to discuss any financial arrangements with their patients that could affect care.
- The House adopted policy that patenting naturally-occurring substances is not unethical per se and made four recommendations in this area.

Reference Committee D

- In reviewing a Council on Scientific Affairs Report on medical use of marijuana, the House adopted a strong statement on the sanctity of physician-patient communication. The report was amended to call for the "free and unfettered exchange of information on treatment alternatives" (not restricted to issues of medicinal marijuana). The House also spoke overwhelmingly in support of the scientific study of potential medical uses of marijuana, calling for the NIH to facilitate controlled, clinical studies on its potential use for AIDS wasting syndrome, cancer cachexia, nausea due to chemotherapy, spasticity and neuropathic pain. This action rejected calls for blanket protection of the medicinal use of marijuana.
- The House restated AMA opposition to any civil immunity for the tobacco industry. This policy, from June 1997, is based on overriding concern for the health of the public, an essential part of the AMA's core purpose.
- The House acted favorably on several other public health issues, adopting actions that: support National Alcohol Screening Day and encourage physician participation; support improved access to chemical dependency treatment programs; will inform physicians about possible abuse of dextromethorpan; will seek limits on smoking near the entrances to public buildings; and will inform physicians of potential misuse of benzodiazepines, particularly as used in sexual assault cases.
- The House emphasized that public health efforts must be grounded in

science, adopting a report of the Council on Scientific Affairs on helmet use by skiers recommending that the AMA not support mandatory helmet use given the lack of evidence on their value and cost effectiveness. Similarly, the House called for study of the effectiveness of protective gear for skateboarders and in-line skaters prior to any mandate for its use.

Reference Committee F

- The House adopted detailed recommendations of a comprehensive Board of Trustees report on AMA corporate relationships, including 13 "Principles to Guide Corporate Relationships." This report responded to AMA's agreement with Sunbeam Corporation and subsequent events. It outlines the steps taken by the Board to ensure that AMA business relationships are appropriate and based on the AMA's vision. The House also received a report of the AMA Board/Staff Liaison Committee on AMA corporate arrangements and management practices.
- The House created an Ad Hoc Committee of the House of Delegates to deal with any items related to the Sunbeam arrangement not fully addressed in a September 1997 "Counsel's Memo" on this matter, with a report to the House at its June 1998 meeting. The House also appointed an Ad Hoc Committee of the House to study the structure, governance, and operations of the House and the Board, using the services of an independent management firm to evaluate key internal decision-making processes, with a report to the House in June 1998.
- The House adopted the action-oriented recommendations in a Board of Trustees Report that outlines the need to transform the value of membership in organized medicine and outlines needed House actions. The House also created a new House of Delegates Task Force on Membership that will report on its efforts to identify and report on ways to increase recruitment and retention of AMA members by the June meeting of the House.

Reference Committee G

- The AMA adopted major new policy on two approaches increasingly used to influence or control the utilization of health services: disease management and demand management through telephone triage. A Council on Medical Service report described similarities and differences between these approaches, reviewed their growth, presented evidence on effectiveness, and established 19 principles that should apply in their operation.
- In response to concerns over the inappropriate use of Milliman & Robertson Guidelines by managed care plans and other health insurers, the AMA will seek the cooperation of the National Committee for Quality Assurance in studying the guidelines. In addition, the AMA will continue to provide assistance to AMA members who report problems with the inappropriate use of Milliman and Robertson Guidelines.
- The House adopted policy to continue to seek enactment of comprehensive legislation on a wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan policies. The AMA will also seek elimination of clauses in managed care contracts allowing refusal to pay for covered services solely because required notification of these services was not reported in a timely manner. The House also established five patient-focused principles for development of rural community health networks.

Reference Committee H

- Responding to growing concern about provision of home health services and the need for greater physician oversight of these services, the AMA adopted policy to inform physicians of their responsibility in certifying home health services. The AMA will also urge the Health Care Financing Administration to clarify the definition of homebound patients and simplify the forms required for certification of home health care services.
- The AMA will increase its efforts to abolish the National Practitioner Data Bank, a clearinghouse of names of all physicians named in malpractice suits. The AMA has long opposed the use of this data as many malpractice suits are settled out of court and a final adverse action has not been taken by a medical licensing jurisdiction.
- The AMA reaffirmed support for the American Medical Accreditation Program (AMAP), calling for medical staffs to use AMAP as the source of information in their appointment, reappointment, and credentialing of medical staff members, and to encourage their members to become AMAP accredited. The AMA did, however, also acknowledge and apologize for communication problems between AMAP and the Federation and will direct attention to improving communication and cooperation with the Federation.
- The AMA will study the new emergence of primary care physicians practicing primarily in hospitals, or "hospitalists" and determine ramifications for continuity of care, quality of care, the physician/patient relationship, and overall costs. The AMA will also study how primary care physicians

will be able to maintain their skills, full scope of practice, and health plan membership if this trend continues.

- **Immediately before the House meeting, the AMA obtained from HCFA an extension of the grace period for enforcement of the evaluation and management (E/M) documentation guidelines.** Physicians may use either the 1994 or the 1997 version of the guidelines until July 1, 1998. The House then adopted policy to reduce documentation requirement burdens for E/M services, ensure that documentation or inadvertent errors in the patient record that do not meet E/M guidelines, does not, in and of itself, constitute fraud or abuse. The AMA will also facilitate additional review and take corrective action on excessive content of the guidelines and work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies, urge HCFA to establish a test period for the guidelines and adopted policy that medical documentation of items unrelated to the care provided (ie, irrelevant negatives) not be required. In another coding-related issue, the policy was adopted that AMA take steps to ensure that payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services.

While you're looking out for your patients, who's looking out for you?

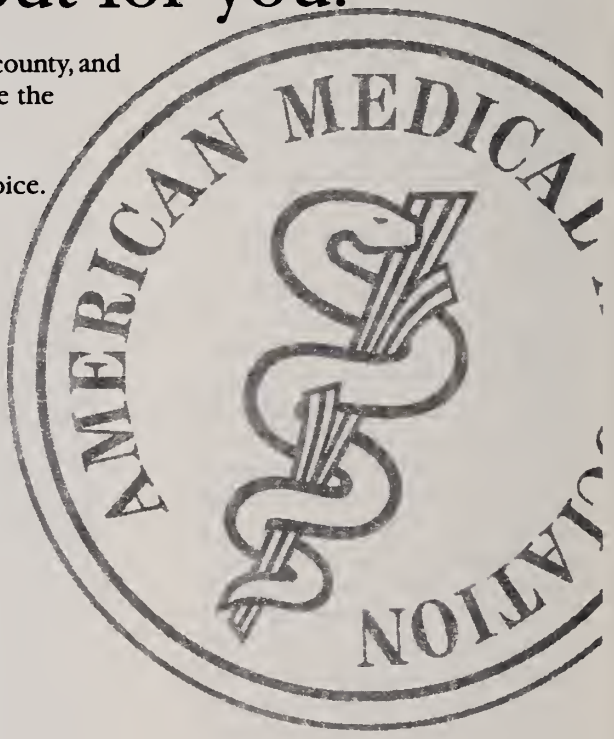
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PEOPLE

Bruce A. Scott, MD, a Louisville otolaryngologist, is seeking a position on the AMA Board of Trustees in a slot designated for a Young Physician. He currently serves as the sole Delegate to the AMA House of Delegates from the AMA Young Physicians Section.

Stephen P. Wright, MD, has been named Eastern Kentucky University's 1997 Outstanding Alumnus. He is medical director of Kosair Children's Hospital in Louisville.

Ardis D. Hoven, MD, a past president of KMA and current Delegate to the AMA from Kentucky, is running for a position on the AMA Council on Medical Service which deals with managed care, insurance, and reimbursement issues. Dr Hoven currently serves on the Practicing Physicians Advisory Council to HCFA as a nominee of the AMA.

Donald C. Barton, MD, Kentucky's Senior Delegate to the AMA, just completed a 2-year term as Chair of the Southeastern Delegation, a coalition of 13 states, the District of Columbia, and Puerto Rico. During his tenure, the Delegation has supported three candidates from Kentucky for AMA positions.

Will W. Ward, Jr, MD, has received an Alumni Service Award from the University of Louisville. A Louisville physician, Dr Ward has been interested in serving the needy since he was a medical student at the University. His services have included giving charity care at the Mission House and co-founding the Greater Louisville Organization for Health Clinic.

UPDATES

Retention of Medical Records

KMA continues to receive numerous inquiries on how long medical records should be retained in physician offices. Retention of records is important because federal and state auditors may want access to records going back as far as 5 to 6 years. Records are also important in liability claims. Physician offices should keep the following points in mind:

1. In Kentucky, anyone may sue a physician for malpractice one year from the time a problem is discovered. A problem may not be discovered until many years after the physician performs a procedure, so, it is always wise to maintain records indefinitely. Physicians should consult their liability carriers for additional advice.
2. If physicians do not want to maintain records indefinitely, they should maintain them at least 6 years because that is the statute of limitations on prosecution for most fraud and abuse cases.
3. Medicare and Medicaid regulations require that records be kept at least 5 years.

Health Payments 30 Days Late? You Have Recourse

Kentucky law states that any claim "arising under the terms of any contract of insurance shall be paid to the named insured person or health care provider not more than thirty (30) days from the date upon which notice and proof of claim, in the substance and form required by the terms of the policy, are furnished to the insurer." If a plan does not make payment within 30 days, interest at an annual rate of 12% will be charged on the amount.

The law doesn't specify whether this right to payment within 30 days can be contracted away. In other words, a health plan may try to have a physician sign a contract that specifies the plan may pay whenever it wishes relieving them from the obligation to pay within 30 days.

A Plan of Action—

- Inform the health plan in writing that you have not received payment; ask them why and point out that Kentucky law states they must pay within 30 days of receipt of the claim. You may also want to consider telling the plan you intend to contact the state Insurance Commissioner if you are not given a good reason for the nonpayment. Also inform them Kentucky law provides that you are to receive 12% interest on the amount. Always remember, however, that the plan may be able to terminate you from the plan's panel without cause.
- When your contract with the plan comes up for renewal, consider placing clauses in the contract that (1) define a "clean claim," (2) clearly state the plan will pay interest if the payment is late and (3) clearly state the plan will comply with Kentucky state law regarding late payments.
- Physicians may want to purchase a rubber stamp citing the relevant Kentucky law on late payment and stating that interest will accrue on the claim if not paid by a specific date.

E & M Guideline Extension

HCFA is delaying enforcement of the new Evaluation and Management documentation guidelines until July 1, 1998. While the continued use of 1994 guidelines will be accepted, HCFA strongly encourages physicians to begin using the new guidelines now. The new guidelines will be published in the Medicare bulletin and are available on the HCFA Web site: http://www.hcfa.gov.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Kaukwok Frederick Ho MD — OPH
102 B Lyon Ave, Glasgow 42141
1982, Washington U, St Louis

Boyd

Cecilia D Gaynor MD — ID
2222 Winchester, Ashland 41101
1989, U of Cincinnati

Boyle

Colin R Raitiere MD — FP
109 Daniel Dr, Danville 40422
1977, U of California, San Francisco

Campbell

Anthony W Alvarez MD — P
224 Grandview Dr, Ft Mitchell 41017
1990, U of Kentucky

Christian

Mohammad Y Bhaghani MD — P
108 Hunting Creek Ct, Hopkinsville 42240-4823
1985, Dow, Pakistan

Fleming

Vicki L Verburg MD — GP
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1991, U of Louisville

Franklin

Brenda A Osborne MD — PD
4 Physicians Park, Frankfort 40601
1989, U of the West Indies, Jamaica

Fulton

George R Hand MD — IM
300 N Highland Dr, Fulton 42041-1437
1962, U of Autonomous of Neuvo Leon, Mexico

Jefferson

Carla Maria Alcid MD — PD
Division Of Pediatric Emergency Medicine, Louisville 40292
1987, U of the Philippines

Michael G Alt DO — N
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1982, Philadelphia Coll of Osteopathic

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101 Chapel Creek Trl, New Albany 47150
1993, U of Cincinnati

Robert O Buse MD — R
10610 Hobbs Station Rd, Louisville 40223-2671
1992, U of Cincinnati

Arnold Michael Conforti MD — S
14007 Hickory Ridge Rd, Louisville 40245
1986, Georgetown

Tim J Conrad MD — OPH
5810 Bonfire Dr, Louisville 40207
1991, Duke

Candace L Embry MD — FP
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1981, U of Kentucky

George F Estill MD — FP
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1980, U of Kentucky

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1994, U of Louisville

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1992, Mayo, Rochester

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1994, Louisiana State, New Orleans

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1991, U of Tennessee

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1991, Case Western Reserve U

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1985, Jawahalal Institute, India

Katherine L Savells MD — PD
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1994, U of Louisville

Lydia E Sims MD — OBG
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1984, U of Pennsylvania

Gregory B Strothman MD — S
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1991, U of Louisville

John C Tackett DMD — DENT
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Brad Michael Watkins MD — S
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1991, U of Louisville

Kenton

Howard A Anneken MD — AN
72 Superior Ave, Ft Mitchell 41017
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1976, Ohio State, Columbus

Laurel

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1982, U of Kentucky

Lyon

David W French MD — FP
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1991, U of Louisville

Madison

Robin A Reams MD — R
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103 Dogwood Cir, Richmond 40475-9626
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1993, U of Kentucky

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1977, U of Baroda, India

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1985, U of Louisville

Venkateswara R Dikkala MD — PD
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1986, Andhra U, India

Pulaski

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1992, U of Kentucky

Warren

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282 Greenview Way, Bowling Green 42103
1988, Wayne State, Michigan

Hugh M Sims MD — OTO
PO Box 3380, Bowling Green 42102-3380
1989, Med Col of Alabama

IN-TRAINING

Boone

Jacob William Vincent MD — FP

Kenton

James Carson Byrd MD — FP
Michael K Dragan MD — FP
Tobin Fisher MD — FP
Maria Fister MD — FP
Kerrick Louis Stout MD — FP
Nicole Renee Williams MD — FP

DEATHS

Carl Pigman, MD
Whitesburg
1906-1997

Carl Pigman, MD, a retired family practitioner, died December 11, 1997. A 1936 graduate of the University of Maryland School of Medicine, Dr Pigman was a life member of KMA.

Robert E. Buten, MD
Ft. Thomas
1926-1997

Robert E. Buten, MD, a retired ophthalmologist, died December 30, 1997. A 1951 graduate of the University of Cincinnati College of Medicine, Dr Buten was a life member of KMA.

Robert J. Seebold, MD
Louisville
1910-1998

Robert J. Seebold, MD, a retired family practitioner, died January 2, 1998. A 1939 graduate of the University of Louisville School of Medicine, Dr Seebold was a life member of KMA.

Paul S. Combs, MD
Lexington
1945-1998

Paul S. Combs, MD, a radiologist, died January 10, 1998. Dr Combs graduated from the University of Kentucky College of Medicine in 1972 and was an active member of KMA.



Accidental Falls: Their Causes and their Injuries

Alvin S. Hyde, PhD, MD
Publisher: HAI
PO Box 490034
Key Biscayne, FL 33149
1996, 251 pages

This is quite a different book. Written in a comfortable style, almost conversational at times, the words do not read encyclopedic as the author apologizes. By incorporating his family to illustrate, research, and review his work, a confluent and elucidating production resulted. Adopting a paperback texture, with larger print and frequent use of bold, underline, and italics, the reading is easy and the searching is really at a minimum.

Dr Hyde divides his chapters by epidemiology, physics, and medicine initially, respecting the fact that his readership varies from scientist, medical personnel, and other lay interested parties. Although complicated by nature, this material easily digests, and surprisingly stays with you through the duration.

The middle of the book takes the biomedical approach, explaining common things like falling, stumbling, tripping, and what consequences to our bodies result from meeting the resistant ground or other objects. In describing how the environment impacts on this subject, Dr Hyde takes us to prophylaxis, his real cause.

While there may be little to do about our anatomy and physiology, about the weather and the local factors, certainly being aware of potential hazards, constructing safeguards, and anticipating future threats is the message.

His filled bibliography, appendix with available books and videos, and a closing last effort at using formulas to come up with numbers for what happens, all complement a very noble effort.

Stephen Z. Smith, MD
Book Review Author

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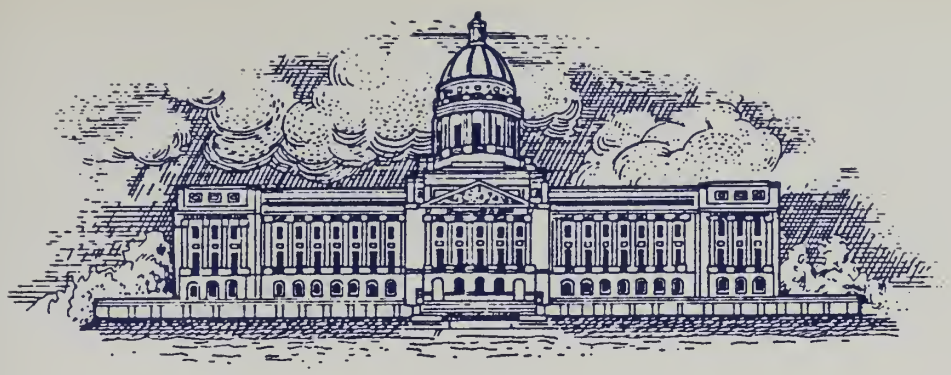
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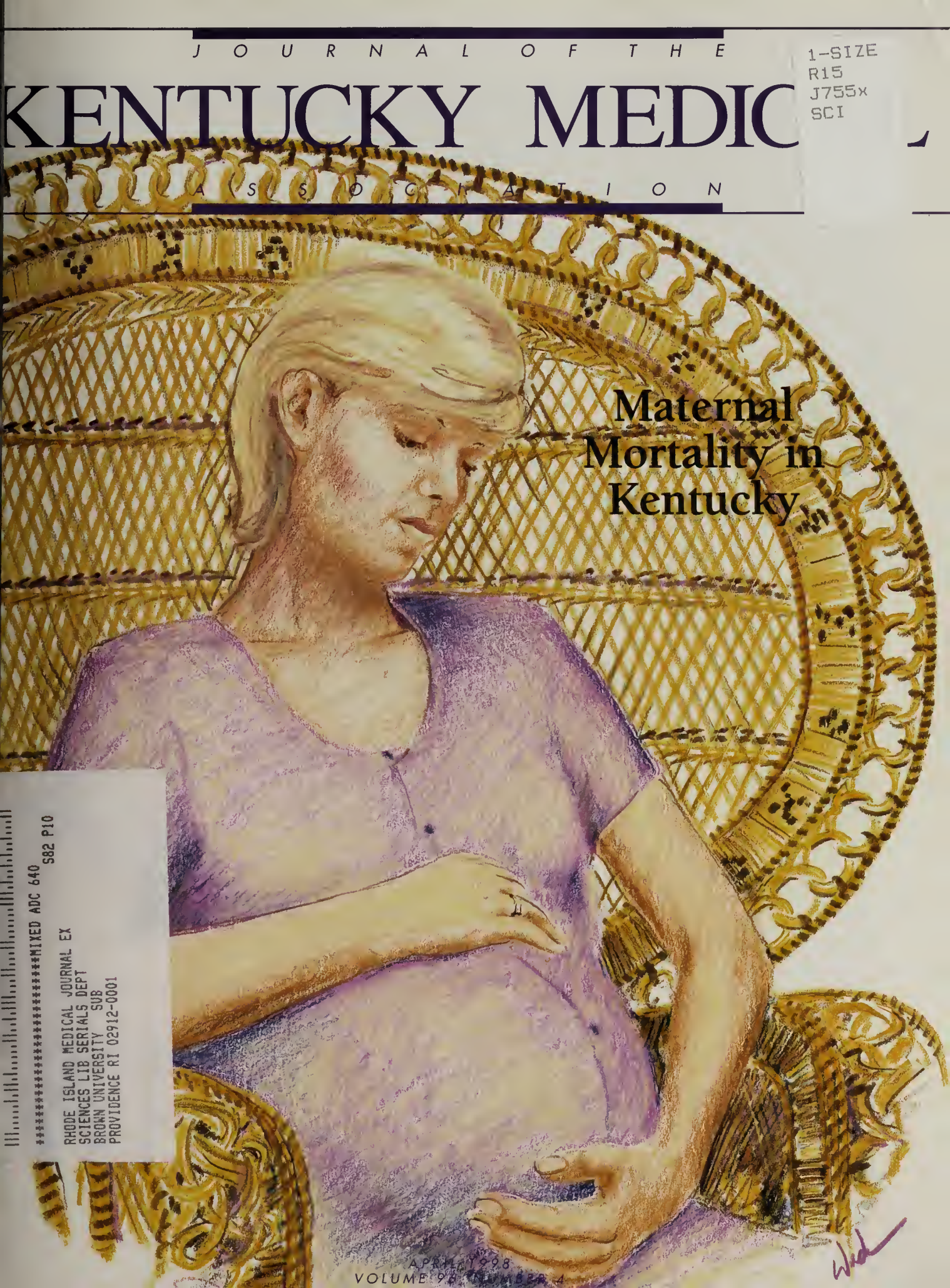


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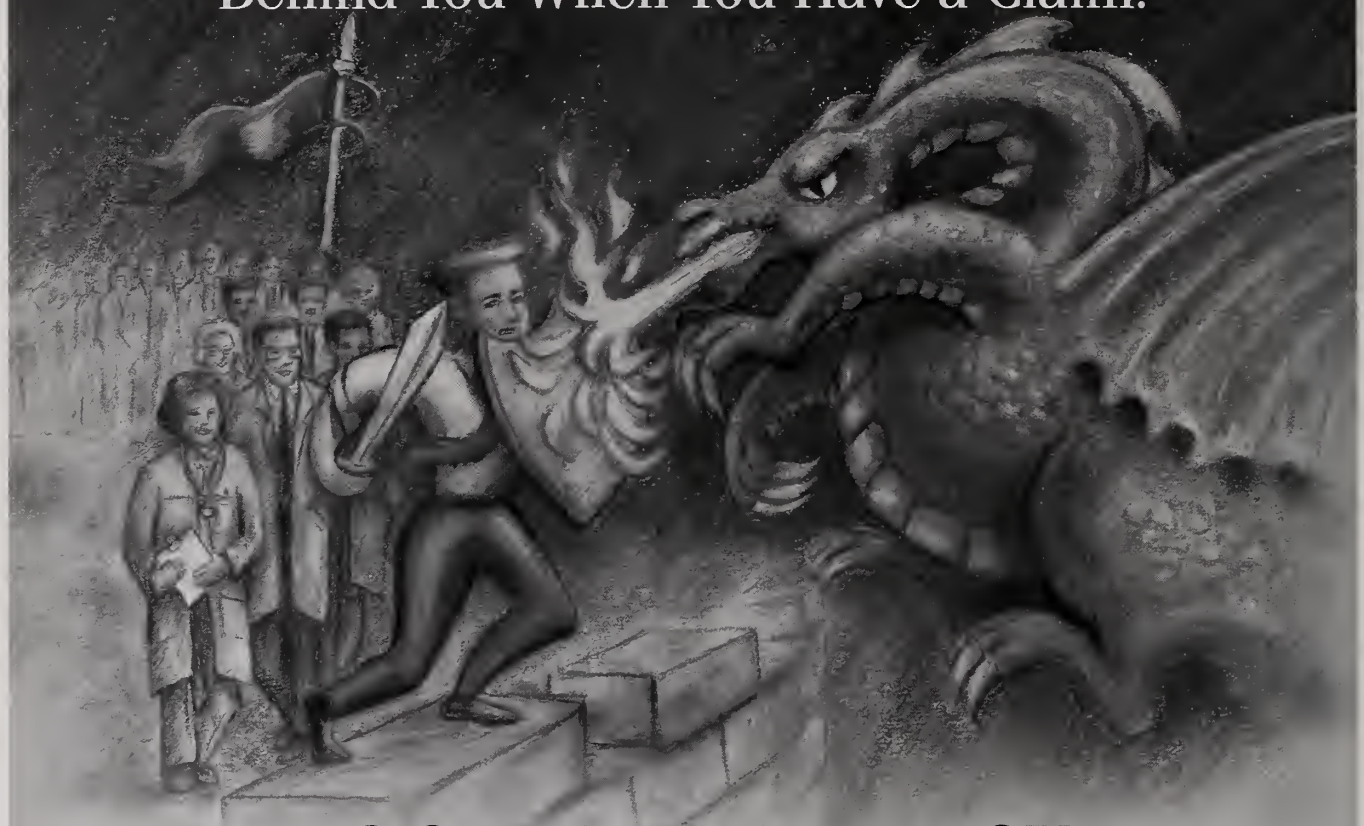


Maternal Mortality in Kentucky

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VOLUME 96, NUMBER 4 APRIL 1998

COVER STORY	Maternal Mortality in Kentucky *Frank C. Miller, MD; John W. Greene, MD; John A. Petry, MD*	**135**
SCIENTIFIC	Spontaneous Vertebral Artery Dissection Resulting in Wallenberg's Syndrome: A Case Report *Bernd Raphael, MD; Goetz Hans Kloecker, MD*	**140**
SPECIAL ARTICLE	Warfarin Vs Enoxaparin for Deep Venous Thrombosis Prophylaxis After Total Hip & Total Knee Arthroplasty: A Cost Comparison *Inigo Garcia-Zozaya, MD*	**143**
EDITORIAL	The Problem With Assumptions *Daniel W. Varga, MD*	**149**
ASSOCIATION	*Monitoring Medicine*	**131**
	KMA Awards Nomination Form	**159**
	News	**156**
	Scientific Exhibits Application	**163**
DEPARTMENTS	President's Page	**129**
	Advertisers' Guide	**162**
	Alliance Page	**151**
	Book Reviews	**155**
	Classifieds	**161**
	Information for Authors	**139**
	Letter to the Editor	**153**



COVER:
Today, the three leading couses of moternol mortality in Kentucky mirror those of the notion, ie, hemorrhoge, pulmonory embolus, ond toxemio. This orticle from the University of Kentucky Department of OB/GYN ond the Kentucky Medicol Associotion Moternol Mortality Study Committee reviews moternol mortality in Kentucky over the 30 year period of 1966 through 1995.

Artwork by Lee Wode of Eminence, KY.

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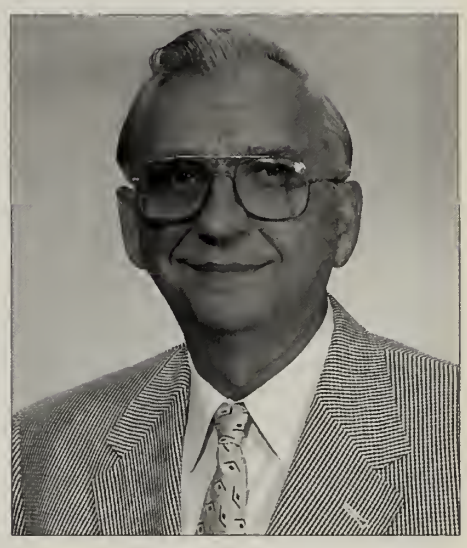
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Get Involved



C. Kenneth Peters, MD

Another regular session of the Kentucky General Assembly has come to a close, and there will be much reflection, both pro and con. The one truth, however, that we can all affirm is that the democratic process is alive and well.

On May 26, our primary to select candidates for 1998 elections will take place. How often do you hear your friends say, "My party selected the wrong person, instead of the one that best reflects my views"? When I hear persons say that, I often wonder whether or not they had really involved themselves in the selection process.

You may call it a mid-year resolution, or a personal commitment—call it what you will—but resolve to **involve yourself** in our state and nation's political system in 1998. This year is not a presidential election year, but one third of the seats in the US Senate are at stake, as well as 535 seats in the US House of Representatives. Thousands of seats in state legislatures across the country (including Kentucky) will be filled in 1998. Locally, the future of schools, hospitals and essential social services are in the hands of local governing bodies. Medicaid, managed care, and many other issues are on the table in our local arenas.

"The extent of the success of our Association efforts is directly related to our success in the political arena. If you and I are not participating, then we lessen our collective ability to solve our problems."

Nationally, a priority issue is Medicare. Our AMA has warned us for years that Congress must act to strengthen the financial structure of this program before bankruptcy occurs. Congress will probably take action in 1998; as physicians we must be at the table in developing a long term solution to Medicare funding.

Political involvement can take many forms. It may be as basic as becoming informed about the issues, registering to vote—**and voting**. It may include actively supporting the candidate of your choice. Many physicians and their spouses provide this support by joining KEMPAC. Of even more value to candidates are the many physicians and spouses who serve as campaign workers and volunteers, performing tasks from stuffing envelopes to hands-on campaign management.

As leaders and staff at KMA, we are always delighted to hear from our members when they have a particular issue or concern, and we appreciate the high level of trust our membership has in our organization. The extent of the success of our Association efforts, however, is directly related to our success in the political arena. If you and I are not participating, then we lessen our collective ability to solve our problems. As an organization, we have one of the most effective legislative teams that has ever been assembled in Frankfort.

Recently, a fellow physician called KMA and asked staff to help him identify his legislative representative, which staff was delighted to do. It was a healthy sign that physician was getting involved. All of us enjoy debriefing in the doctor's lounge, but dear friends, if our concern never goes beyond that setting, our voices are never heard where it matters. **Get involved and help us protect quality health care in Kentucky. Get involved and help us protect the integrity of our most precious possession—the doctor-patient relationship.**

"All of us enjoy debriefing in the doctor's lounge, but dear friends, if our concern never goes beyond that setting, our voices are never heard where it matters."

Unless we choose to participate, however, our voices and our fundamental rights as citizens are silenced. **Get involved!**

C. Kenneth Peters, MD
KMA President

There's a 5:00 meeting about your practice, and you're not invited.



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KEMPAC

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502.426.62000 ★ Fax 502.426.6877

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. A portion of the voluntary contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions to KEMPAC and AMPAC are not deductible as charitable contributions for Federal Income Tax Purposes.

NEWS FOR KENTUCKY PHYSICIANS

Physician Protections from Any Liability for Serving on Peer Review Panels

by Harry W. Carloss, MD

A hospital owes a legal duty to its patients to exercise reasonable care in the selection of its medical staff and in granting medical privileges. Physicians often participate in the process of selecting medical staff because they are in the best position to provide pertinent input. In order to assure the best and most honest "peer review" is conducted, state and federal governments have provided immunity from lawsuit to those who serve on peer review panels.

The Kentucky legislature has also enacted legislation which said documents regarding peer review are not open to the court system, or, in legalese, "discoverable."[1] The Kentucky courts, however, continue to erode these statutory protections given to peer review records. The legislature has made it very clear that such records are not subject to discovery "in any civil action in any court," but, the latest decision by Kentucky's Supreme Court on this issue says the protection from discovery only applies to actions by physicians against a medical staff, but, does not apply to claims of medical negligence and corporate negligence.[2] The Court's ruling in this area continues to subject peer review documents to discovery in civil trials.

The idea of protecting such records from discovery is not a novel one and almost all states currently have such a law. The law allows for uncolored and frank discussion by peer review organizations by easing the worry of such discussions being open to the court system. Such a policy provides for quality peer review, which is important to provide quality care. The Kentucky Medical Association has continually worked to pass legislation that makes it clear such records are not open to discovery. Our views have also been expressed to administration officials, stressing to them the importance of such records having as much protection as possible.

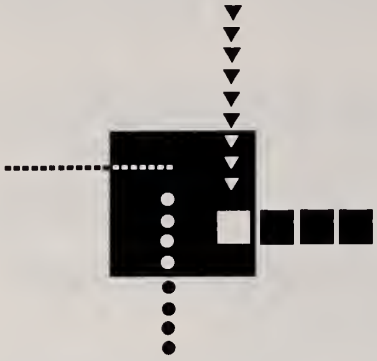
Since peer review records do appear to be subject to discovery, it is important for physicians to protect themselves from lawsuits that may arise as a result of their service on peer review panels. Of course, anyone can sue and that is why it is important to ensure the cost of defending such a suit is incurred by someone other than the physician. The protections discussed below may prevent physicians from incurring the cost of defending themselves in a lawsuit regarding their service on peer review panels.

- Kentucky law provides that a person who has applied for staff privileges waives any claim for damages for any good faith action taken by someone who serves on a peer review panel.[3]
- Physicians may also have protection from lawsuits under the Federal Health Care Quality Improvement Act, which has been incorporated into Kentucky's peer review statute.[4]
- Physicians should be careful when reviewing others within the same specialty. Federal law addresses whether a specialist who is in direct competition with another specialist may review the specialist with which he is in competition.
- Physicians can contract with hospitals to defend, indemnify, or hold physicians harmless for any claim arising out of their service on a hospital's peer review panel.
- By-laws of the hospital itself may provide coverage for physicians who serve on peer review panels. Physicians should ensure this section of the hospital bylaws is incorporated into their contract with the hospital.
- Some hospitals also include provisions in the bylaws of the medical staff which provide that the hospital will defend, indemnify, and hold the medical staff harmless against claims arising out of their performance of peer review functions.
- Physicians should check with their own liability carrier to see if coverage can be obtained for serving on a peer review panel.

Harry Carloss, MD, currently serves as Vice-President of the Kentucky Medical Association.

[1] KRS 311.377(2)
[2] *Leanhart v. Humana, Inc.*, KY., 983 SW2d 820 (1996)
[3] KRS 311.377(1)
[4] 42 USC 11151

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

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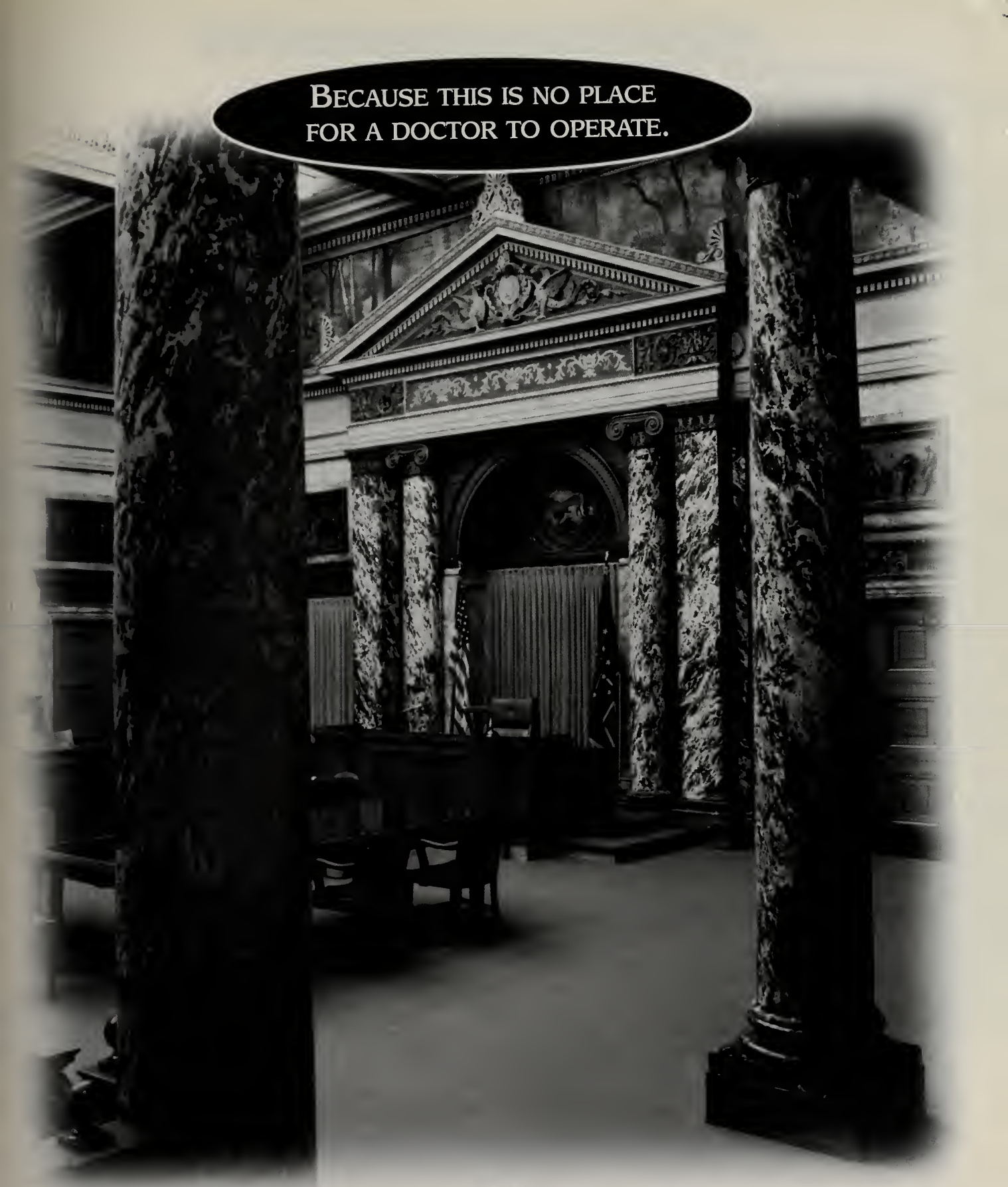
- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
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* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

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Maternal Mortality in Kentucky

Frank C. Miller, MD; John W. Greene, MD; John A. Petry, MD

This paper reviews maternal mortality in Kentucky over the 30 year period of 1966 through 1995. Data were reviewed from the minutes of the State Maternal Mortality Study Committee and the reports of the State Cabinet of Health Services, State Centers for Health Statistics. There has been a marked fall in the number of births during this 30 years and an even more dramatic reduction in maternal mortality. Identifiable causes for maternal death have changed over the years. Today, the three leading causes of maternal mortality in Kentucky mirror those of the nation, ie, hemorrhage, pulmonary embolus, and toxemia.

Maternal mortality has been tremendously reduced in this country in the last 200 years and more so in the last 50 years.[1] When Mary Todd Lincoln was born in Lexington in the early 1800s, it is said that one out of eight women died during or after pregnancy.[2] Her mother, Eliza, died after the birth of a son in 1825. She had had seven pregnancies in twelve and a half years. Maternal mortality in the United States came under scrutiny in the 1930s when committees of hospitals, health departments, and local medical societies began to collect information on the maternal deaths in their area.

Throughout the nation, despite the best efforts of state health departments' vital statistic divisions, there is a consistent underreporting of maternal deaths.[3-6] The causes for this underreporting are many and vary from state to state, but some of the most common problems are that 1) deaths are coded according to the International Classification of Disease — 9 (ICD-9) codes 630-676, which do not include all of the causes of pregnancy related deaths, 2) states use varying criteria for pregnancy related deaths, ie, some states include all pregnancy related deaths up to 1 year after pregnancy, while others limit the time frame to 3 or 6 months, 3) in some states, death certificates have check boxes to mark pregnancy, but most do not, 4) there is some reluctance to identify pregnancy related deaths because of fears of malpractice litigation. It is estimated that as many as one-half of all maternal deaths are unreported, ie, the deaths are not categorized as pregnancy related.[3,4]

The maternal mortality rate, defined as the number of deaths per 100,000 live births occurring during or within 1 year of pregnancy termination and resulting from: 1) complications of pregnancy itself, 2) a chain of events initialized by pregnancy, 3) aggravation of an unrelated event by the physiologic effects of pregnancy. As previously mentioned, this definition of maternal mortality does not include deaths from accidents, ie, auto accidents, murder, or suicide.

Materials and Methods

In the 1960s, the Maternal Mortality Study Committee (MMSC) was organized by the Kentucky Medical Association with support of the Division of Maternal and Child Health Services of the Kentucky State Health Department. This committee began reviewing all death certificates of females between the ages of 15 and 44 years. The committee meets 1 to 3 times a year depending upon the number of cases. Material is gathered by the state health department from sources in Frankfort and by physicians and/or hospitals reporting to the authors of this paper. On occasion, maternal deaths were obtained from newspaper sources. The committee has rotated members every 3 to 5 years and generally has consisted of 8 to 24 physicians from various geographic areas of the state. A medical student and a resident in obstetrics and gynecology usually attend and take part in discussions. The deaths are reviewed at great length and time is given to etiologic factors. The deaths are classified as direct or indirect obstetrical as well as identifying preventable factors such as physician responsibility, medical care facility availability, and/or lack of patient compliance. It is from the Committee minutes and reports over the past 30-plus years that most of the details on maternal mortality for this report were gathered. A detailed review of all maternal deaths from 1966-1976 was presented by the committee in late 1976.[7]

In its deliberations, the committee considers

From the University of Kentucky Deportment of Obstetrics & Gynecology, Lexington, KY (Drs Miller ond Greene); ond the Moternal Mortality Study Committee, Kentucky Medicol Associotion, Louisville, KY (Dr Petry, Secretary).

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whether there is any one institution, physician, or locality with repetitive problems needing further study or action.

In 1974, the State Cabinet for Health Services, State Center for Health Statistics began reporting maternal deaths by International Disease Code — 9 (ICD-9) codes. The state Maternal and Child Health Department provided detailed information on the number and etiology of maternal deaths from the Center of Health Statistics from 1974 through 1995. These two sets of data were then compared in an attempt to determine the most accurate annual number of maternal deaths and the most common complications contributing to maternal mortality in the state of Kentucky during the 30 years from 1966 through 1995.

This report is divided into three 10-year periods, 1966-75, 1976-85, and 1986-95. During the 1966-75 period, the data source was the MMSC report; during the next two 10-year periods, both the MMSC and State Health Statistics were compared.

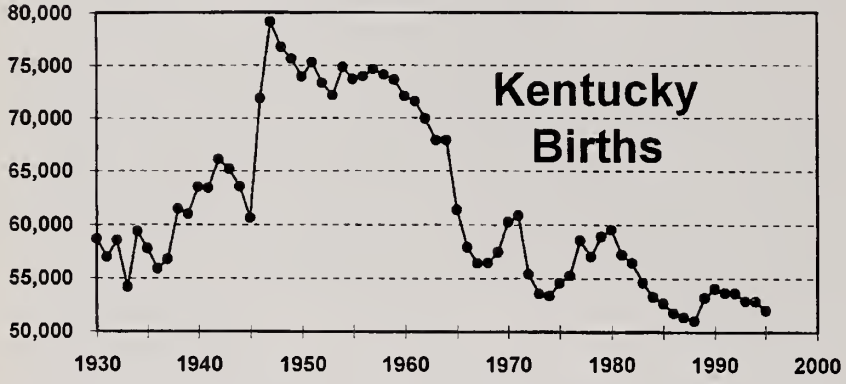


Fig 1 — Annual births in Kentucky from 1930 through 1995.

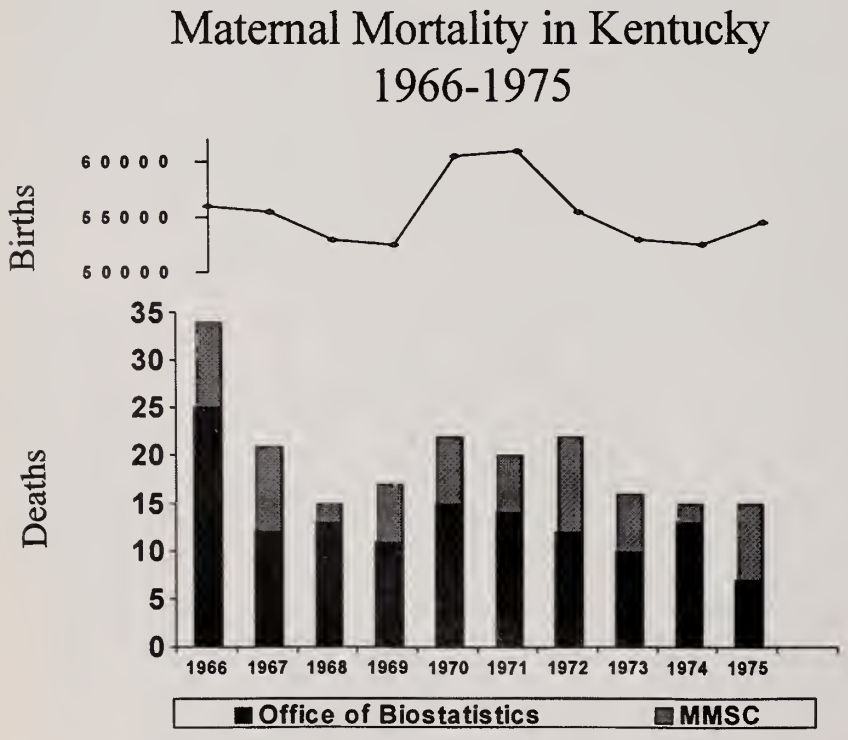


Fig 2 — The number of births per year from 1966-1975 depicted at the top. The total number of maternal deaths as reported by the State Office of Biostatistics is shown in dark bars and those reported by the Maternal Mortality Study Committee in the lighter hatched bars.

Results

Births in Kentucky continue on a downward trend that began in the 1950s. The number of annual births during the past 30 years has ranged from just under 52,000 to 62,000. During the 20 years prior to 1965 (post World War II baby boom) the delivery rate ranged from 70,000 to 80,000. A precipitous drop in births occurred in 1964-65, the year just preceding this review (Fig 1). The birth rate for Kentucky and the nation were strikingly similar until 1980. Subsequently Kentucky has had a lower birth rate than the national average.

Maternal Mortality 1966-76

There is a persistent discrepancy between the total number of maternal deaths reported by the MMSC and the State with the MMSC always reporting more deaths. During the 10 years from 1966-75, the differences ranged from 11 in 1966 to 2 in 1968 and 1974. Keep in mind that the state based their reports on death certificates alone, while the MMSC investigated all female deaths between the ages of 15 to 44 years. The number of maternal deaths annually as reported by the MMSC and the State Office of Biostatistics as well as the number of births are shown in Fig 2. The number of deaths fell rapidly from a peak of 34 in 1966 to 15 in 1975 (MMSC reports) while the number of births initially rose and then fell.

The most frequent cause of maternal death during this period was hemorrhage, followed by sepsis and toxemia (Table 1). There was a marked decrease in deaths due to hemorrhage beginning in 1972 and persisting through 1975. The large category listed as "others" was from the State Office

Table 1. Maternal Deaths in Kentucky MMSC 1966-1975

Cause	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	Tatal
Hemarrhage	11	6	8	4	9	6	2	3	3	1	53
Sepsis	5	8	0	3	3	2	2	4	4	1	32
Taxemia	2	2	2	2	5	5	2	1	2	1	24
Other	16	8	5	8	5	7	16	8	6	12	91
Tatal	34	24	15	17	22	20	22	16	15	15	200

The leading causes of maternal death and the total reported maternal deaths in Kentucky as reparted by the Maternal Martality Study Cammittee far the decades af 1966-1975.

of Biostatics under the exact heading of "all other complications of pregnancy, childbirth, and puerperium." At the time of this paper, that large category could not be more accurately defined. The total number of maternal deaths in this 10 years was exactly 200.

Maternal Mortality 1976-85

The gap between the number of maternal deaths reported by the MMSC and those reported by the state persisted (Fig 3). For this 10 year period, the MMSC reported 92 maternal deaths, while the state recorded only 49. Although during 2 years, 1980 and 1982, the number of maternal deaths exceeded 10, the trend was downward and the total number of deaths for this 10 years was more than 100 fewer than the previous 10 year period.

There was a shift in the most frequent causes of maternal deaths in this time period. Although hemorrhage remained the major killer, pulmonary embolism, both amniotic fluid and vascular, became the second most common cause. During this time, anesthesia was identified as causing 5 deaths, which exceeded the number of deaths for sepsis and toxemia (Table 2). There was still a large category of "other." One or two of these deaths were during or immediately following pregnancy, but not related to the pregnancy. Others are difficult to categorize, ie, congenital

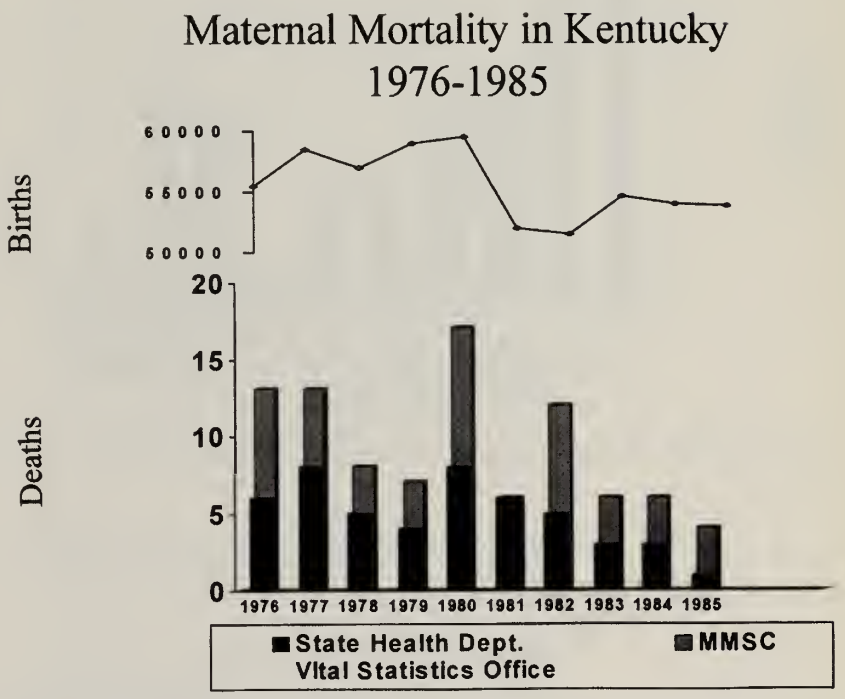


Fig 3 — Shows the number of births and maternal deaths each year from 1976-1985.

Table 2. Maternal Deaths in Kentucky 1976-1985

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	Total
Hemarrhage	2	3	2	2	6	3	4	2	2	1	27
Sepsis	0	2	1	0	0	0	0	0	1	0	4
Taxemia	0	0	0	1	3	0	0	0	0	0	4
Pulm. Embolism	4	3	3	0	3	1	2	1	0	1	18
Anesthesia	3	0	1	0	0	0	0	1	0	0	5
Other	5	4	1	4	5	2	6	4	3	0	34
Tatal	14	12	8	7	17	6	12	8	6	2	92

This table includes a listing af all maternal deaths in Kentucky and the leading causes each year fram 1976-1985.

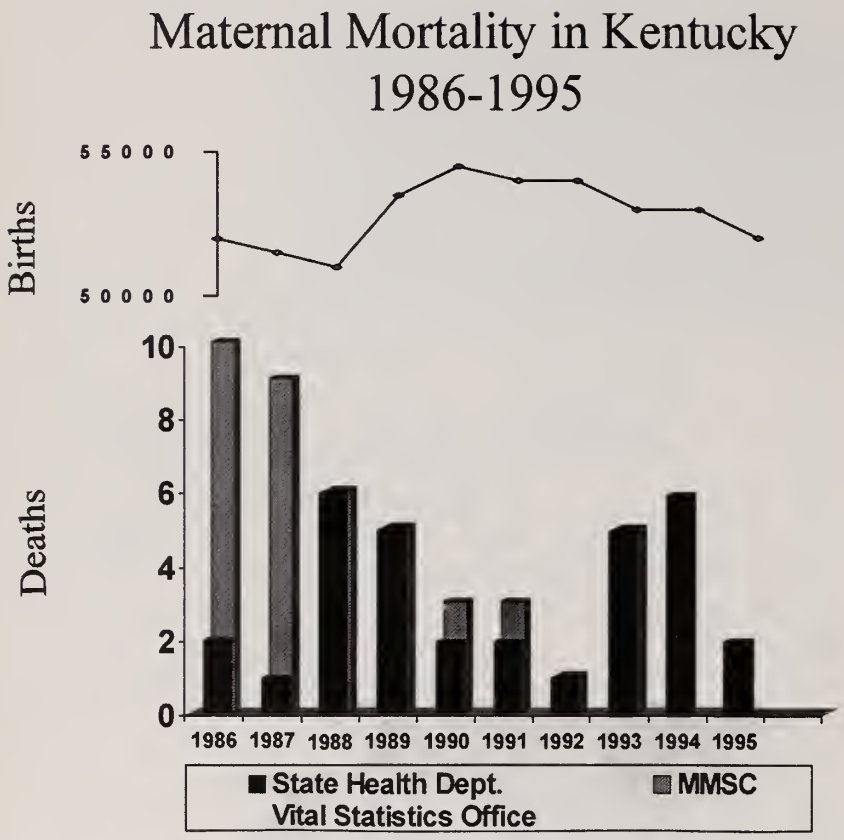


Fig 4 — Depicts the births and maternal deaths for the decade 1986-1995.

abnormalities of the uterus (2 deaths), maternal distress (2 deaths), and other obstetrical conditions (6 deaths).

Maternal Mortality 1986-95

The number of reported maternal deaths continued to decrease. During the most recent 10 years, 39 deaths were reported (Fig 4). While this continued fall is very encouraging, it must be remembered that it may take 3 to 4 years to make sure that all maternal deaths for a given year have been investigated and reported. It is most likely that the number of deaths for the years 1993, 1994, and 1995 will go up once all the potential cases have been investigated. For these 3 years, the State Vital Statistic numbers were utilized.

As in the previous 20 years, hemorrhage was again the leading cause of maternal mortality. Pulmonary embolism, toxemia, and sepsis round out the top four. These four combined, account for 70% of pregnancy related deaths (Table 3). Although infrequent, death from sickle cell crisis was reported four times during this review. As with anesthesia accidents and most cases of hemorrhage and sepsis, these deaths should be preventable.

Discussion

The most difficult state or national death statistic to obtain is maternal mortality.[3-6] Accurate data depends on the awareness of the importance of specific, concise, and timely recording of the causes of death in all women, but especially those during the reproductive years (15-44). It also requires the cooperative efforts of state officials, physicians, and concerned citizens to develop a working system to record, collect, and analyze the data. Kentucky has been fortunate to have an interested and dedicated group. Continued improvement in surveillance will give us a better picture of events associated with pregnancy related deaths and ultimately allow more accurate monitoring of trends within our state and nation.

Further review might answer questions such as the effects of availability of care, physician training, hospital and ancillary support (anesthesia and blood immediately available), transportation, prenatal care, race, cesarean section rates, and many other potential factors on the overall maternal mortality rate. It can serve as a benchmark for the overall number of deaths and the

Table 3. Maternal Deaths in Kentucky 1986-1995

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	Total
Hemorrhage	3	0	1	1	2	1	0	3	1	1	13
Sepsis	0	0	0	1	0	0	0	1	0	1	3
Toxemia	2	0	2	1	0	0	0	0	0	0	5
Pulm. Embolism	1	0	1	0	0	1	0	1	2	0	6
Other	4	1	2	2	0	0	1	0	2	0	12
Total	10	1	6	5	2	2	1	5	5	2	39

The number of maternal deaths for this most recent decade are underreported because all maternal deaths have not been reported and investigated at this time.

most common causes of maternal mortality. It is reassuring that the maternal mortality rates continue to decline. Kentucky reports the same four leading causes of maternal mortality as the national data — hemorrhage, sepsis, toxemia, and pulmonary embolism.

In a report by the Center for Disease Control and Prevention, they concluded that more than half of maternal deaths are probably unreported.[3,4] They found that a variety of methods can be used to improve the ascertainment of maternal death, including linkage of birth and fetal death certifications. Kentucky death certificates do not have a space to indicate whether the woman was pregnant, although they did at one time. This mistake should be corrected and this simple notation reestablished.

Lastly, it should be stated that factors other than the traditional hemorrhage, infections, and hypertensive disorders of pregnancy have surfaced. Nationally, HIV infections and trauma have been revealed to be major factors and death may occur outside the traditional 30 to 90 day postpartum. In a recent report, Donnenbery et al[6] concluded that homicide and other injuries are major contributors to maternal mortality and should be (but rarely are) included in the maternal mortality surveillance system.[6]

Conclusion

Maternal mortality in Kentucky, as in the developed countries, has been greatly reduced. One-half the deaths may not be directly related to the pregnancy. Therefore, the etiology of maternal deaths is changing and we must continue to carefully monitor these catastrophic events.

References

1. *Williams Obstetrics.* 20th ed. Appleton & Lange. Simon & Schuster Co; 1997: p3.
2. Baker JH. *Mary Todd Lincoln.* New York, NY: W.W. Norton & Company; 1987: p20.
3. Berg CJ, Atrash HK, Koonin LM, et al. Pregnancy-related mortality in the United States, 1987-1990. *Obstet Gynecol.* 1996;88(2):161-167.
4. Atrash HK, Alexander S, Berg CJ. Maternal mortality in developed countries: Not just a concern of the past. *Obstet Gynecol.* 1995;86:700-705.
5. Stecklov G. Maternal mortality estimation: Separating pregnancy-related and non-pregnancy related risk. *Stud Fam Plan.* 1995;26(1):33-38.
6. Dannenberg AL, Carter DM, Lawson HW, et al. Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991. *Am J Obstet Gynecol.* 1995;172(5):1557-1564.

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Spontaneous Vertebral Artery Dissection Resulting in Wallenberg's Syndrome: A Case Report

Bernd Raphael, MD; Goetz Hans Kloecker, MD

Dissections (D) of vertebral arteries (VA), once thought to be a rare occurrence after significant cervical trauma, now are increasingly found with minor or no discernible history of trauma. This shift is likely due to the fact that the diagnosis can now be made noninvasively using MRI. Spontaneous VAD are predominantly found in middle-aged people. Typically, they present with severe unilateral occipital headache and/or neck pain followed or accompanied by vertebrobasilar ischemic symptoms. We present a case of spontaneous VAD resulting in Wallenberg's syndrome of lateral medullary infarction along with a discussion of risk factors, diagnostic tests, treatment, and prognosis.

Case Presentation

A 30-year-old black male woke up one morning with severe left occipital headache and ipsilateral neck pain which he attributed to his sleeping position. Several hours later he developed ataxia, dysphagia, and left-sided ptosis and blurred vision.

The patient denied any history of trauma, substance abuse, or smoking. He had no significant medical illness in the past except for febrile seizures during early childhood. He was involved in a low-speed motor vehicle accident resulting in a mild whip-lash injury to his neck without any symptoms. Family history was positive for hypertension.

Vital signs were remarkable only for a blood pressure of 172/100. Physical examination revealed left-sided ptosis, miosis, and decreased visual acuity of 20/80 with intact peripheral vision; tongue deviation to the left side; symmetric hyporeflexia; and lateropulsion to the left side when walking. Complete blood chemistries, blood count, lumbar puncture, electrocardiogram, and CT of the head were within normal limits. A MRI/MRA of the head showed occlusion of the left intracranial portion of the VA with a small infarct in the left medullary region.

The patient received intravenous heparin and antihypertensive medication. Warfarin was given for 6 months. The miosis and dysphagia had resolved within several hours of onset, and all other symptoms had improved to near normal over a period of several months.

Discussion

VAD may be divided clinicopathologically into two groups: In one group, the intima separates from the vessel wall obstructing the lumen and patients may present with an ischemic event. In the other group, the adventitia separates from the vessel wall and patients may present with a subarachnoidal hemorrhage.[1] However, the true incidence of VA injuries is difficult to estimate, since a large percentage is probably asymptomatic and remains undiagnosed. A further distinction can be made between intracranial and extracranial VAD.

A VAD is called spontaneous when no history of trauma is elicited. It occurs more often in people in their forties and fifties[2] but has been reported even in children and adolescents.[3] Due to the particular course of the VA through the foramina of the transverse processes of the cervical vertebral bodies and then angulating into the foramen magnum, it seems feasible that sudden head movements exert substantial shearing forces on the vessel walls. Dissections have been reported after violent sneeze,[4] cough,[5] playing tennis[6] or volleyball,[7] aerobic exercises,[8] and even after head turning while driving.[9] Such activities are part of daily life, and the question arises why only a very small number results in clinically overt damage to the VA.

Do certain risk factors predispose a person?

Our patient reported a mild whip-lash injury 6 years ago but had no symptoms at that time. VAD within several weeks or months of trauma have been reported, and a recent MVA within this time frame should prompt a repeat x-ray or CT of the spine to rule out an occult cervical fracture.[10] A traumatic event several years ago has not been reported to be causative. Hypertension has been considered a risk factor for VAD. Several series have shown that patients with VAD have an increased incidence of hypertension over controls.[11] Other factors implicated in the genesis of VAD are cystic medial necrosis, fibromuscular dysplasia, Marfan's syndrome, homocystinuria, congenital or degenerative changes in the arterial wall, and anatomical or pathological characteristics of the VA.[1,12]

Key features suggesting VAD are headache and neck pain and may be caused by irritation to nerve fibers which have been found to innervate the blood vessels.[13] Since headache and neck pain are frequent complaints in the patient population, it is essential to focus on specific characteristics when taking the history. It should be asked whether there is a change from previous headache or neck pain, whether the pain is unilateral, localized posteriorly, sharp in quality, severe in intensity, with sudden onset, monophasic with gradual remission lasting 1 to 3 weeks.[14] While these features are suggestive of VAD, one should keep in mind that VAD may present without any pain or with different types of headache or neck pain.

Neurologic deficits associated with VAD vary widely depending on the localization, size, and number of the infarcted areas, and various syndromes have been described.[15] Microvasculature which branches off directly from the VA, larger branches like the posterior inferior cerebellar artery, or even the basilar artery may partially or completely occlude. Thromboemboli may form and cause more remote damage. Our patient developed Wallenberg's syndrome which is a common complication of VAD.[2,15] Ataxia, dysphagia, and Horner's syndrome were due to a small infarct in the lateral medulla. His impaired visual acuity may have been the result of a thromboembolus to the carina.

While MRI has largely replaced angiography in diagnosing and following VAD, other noninvasive modalities have been proposed. Doppler ultrasonography of the VA is technically difficult but in skilled hands may be of value in following extracranial VAD.[16] Dynamic CT scanning is possibly more useful than regular CT,[17] but bony artifacts make the documentation of brain stem pathology disappointing. Transcranial doppler alone is not helpful in detecting VAD but may be of benefit when combined with duplex ultrasonography.[18] MRI seems to be the test of choice because it is noninvasive and its sensitivity and specificity are close to that of angiography. MRI findings diagnostic for VAD are intramural hematoma, intimal flap, and enhancement of wall and septum.[19] Attention should be paid to the contralateral VA and carotid arteries since often more than one vessel is involved.[2]

Treatment guidelines for VAD are not established at present. This is partly due to the fact that the allover incidence of VAD is rare, and most cases have a favorable outcome with or without treatment.[2] Treatment varies with the type of VAD. Dissections involving the adventitia and resulting in subarachnoid hemorrhage and/or aneurism are often treated neurosurgically. VAD involving the intimal layer and resulting in ischemic events are often treated conservatively with immediate anticoagulation once intracranial hemorrhage has been excluded,[15,20] and surgery is reserved for a few select cases where, eg, multiple emboli complicate the course of the disease.[21] Patients with spontaneous VAD are generally young and otherwise healthy; therefore, contraindications to or complications from anticoagulation are rarely encountered. Whether to use intravenous heparin with or without subsequent warfarin and the duration of treatment remains the call of the treating physician. Most affected people will recover completely or near completely.[2] The positive outcome may partly be due to the fact that the endothelial response upon vascular occlusion to excrete thrombolytic substances,[22] as well as other repair mechanisms, are likely to be intact in these young patients as compared with the arteriosclerotic vessels of older stroke patients.

With easier recognition of spontaneous VAD due to the advent of noninvasive testing, more cases are likely to be diagnosed and followed. This should raise the opportunity to compare different therapeutic approaches in prospective randomized trials in order to develop treatment guidelines and for identification and management of possible risk factors.

References

1. Sasaki O, Ogawa H, Koike T, et al. A clinicopathological study of dissecting aneurisms of the intracranial vertebral artery. *J Neurosurg.* 1991;75:874-882.

2. Mokri B, Houser OW, Sandok BA. Spontaneous dissections of the vertebral arteries. *Neurology.* 1988;38:880-885.
3. Lewis DW, Berman PH. Vertebral artery dissection and alternating hemiparesis in an adolescent. *Pediatrics.* 1986;78:610-613.
4. Gutowski NJ, Murphy RP, Beale DJ. Unilateral upper cervical posterior spinal artery syndrome following sneezing. *J Neurol Neurosurg Psych.* 1992;55:841-843.
5. Herr RD, Call G, Banks D. Vertebral artery dissection from neck flexion during paroxysmal coughing. *Ann Emerg Med.* 1992;21:88-91.
6. Roualdes G, Lartigue C, Boudigue MD, et al. Dissection of the extracranial vertebral artery after a tennis match. *Presse Medicale.* 1985;14:2108.
7. DeBehnke DJ, Brady W. Vertebral artery dissection due to minor neck trauma. *J Emerg Med.* 1994;12:27-31.
8. Pryse-Phillips W. Infarction of the medulla and cervical cord after fitness exercises. *Stroke.* 1989;20:292-294.
9. Hinse P, Thie A, Lachenmayer L. Dissection of the extracranial vertebral artery: Report of four cases and review of the literature. *J Neurol Neurosurg Psych.* 1991;54:863-869.
10. Tulyapronchote R, Selhorst JB, Malkoff MD, Gomez CR. Delayed sequelae of vertebral artery dissection and occult cervical fractures. *Neurology.* 1994;44:1397-1399.
11. Chiras J, Marciano S, Vega Molina J, et al. Spontaneous dissecting aneurism of the extracranial vertebral artery (20 cases). *Neuroradiology.* 1985;27:327-333.
12. Davis JM, Zimmerman RA. Injury of the carotid and vertebral arteries. *Neuroradiology.* 1983;25:55-69.
13. Arbab MAR, Wiklund L, Svendgaard NA. Origin and distribution of cerebral vascular innervation from superior cervical, trigeminal and spinal ganglia investigated with retrograde and anterograde WGA-HRP tracing in the rat. *Neuroscience.* 1986;19:695-708.
14. Silbert PL, Mokri B, Schievink WI. Headache and neck pain in spontaneous carotid and vertebral artery dissections. *Neurology.* 1995;45:1517-1522.
15. Sturzenegger M. Vertebral artery dissection. Clinical aspects, non-invasive diagnosis, therapy — observations in 14 patients. *Nervenarzt.* 1994;65:402-410.
16. Rother J, Schwartz A, Rautenberg W, Hennerici M. Magnetic resonance angiography of spontaneous vertebral artery dissection suspected on Doppler ultrasonography. *J. Neurol.* 1995;242:430-436.
17. Soper JR, Parker GD, Hallinan JM. Vertebral artery dissection diagnosed with CT. *Am J Neuroradiol.* 1995;16:952-954.
18. Sturzenegger M, Mattle HP, Rivoir A, et al. Ultrasound findings in spontaneous extracranial vertebral artery dissection. *Stroke.* 1993;24:1910-1921.
19. Hosoya T, Watanabe N, Yamaguchi K, et al. Intracranial vertebral artery dissection in Wallenberg Syndrome. *Am J Neuroradiol.* 1994;15:1161-1165.
20. Provenzale JM. Dissection of the internal carotid and vertebral arteries: imaging features. *Am J Roentgenol.* 1995;165:1099-1104.
21. Alexander JJ, Glagov S, Zarins CK. Repair of a vertebral artery dissection. Case report. *J Neurosurg.* 1986;64:662-665.
22. Miles L, Levin E, Plow E. Localization of fibrinolytic proteins on peripheral blood cells and endothelial cells. *Circulation.* 1986;74(Suppl II):246.

Warfarin Vs Enoxaparin for Deep Venous Thrombosis Prophylaxis After Total Hip & Total Knee Arthroplasty: A Cost Comparison

Inigo Garcia-Zozaya, MD

Background — *Total joint replacements are high-risk procedures for development of deep venous thrombosis (DVT) and pulmonary embolism (PE), therefore, routine pharmacological prophylaxis should be instituted in all cases. Cost-containment has become an important factor with the present changes in health care. This report presents an economic model for DVT prophylaxis after total hip and total knee arthroplasty (THA & TKA) that approximates closely to the current standards in orthopedic practice, and encourages the balance of clinical and economic considerations in patient care management.* ***Methods —*** *A simplified cost-effectiveness (cost-minimization) analysis, from the consumer's perspective, between Warfarin and Enoxaparin for DVT prophylaxis after THA and TKA, for a total of 15 days, in both inpatient and outpatient settings was used. The costs of drugs, laboratory, and home care services were evaluated through surveying three different providers in each category and obtaining the mean value for each of the services supplied. All providers were located within the Louisville, KY, metropolitan area. Data collection took place in October 1996.* ***Results —*** *The main outcome measure was the difference in cost between the two drugs when all factors associated with therapy were considered. The overall cost of DVT prophylaxis with Enoxaparin was somewhat less expensive ($925.38) when compared to Warfarin ($971.77).* ***Conclusions —*** *Within the limitations of this study Enoxaparin was slightly more cost-effective than Warfarin for venous thromboembolism prophylaxis after total hip and knee arthroplasty.*

Deep venous thrombosis (DVT) remains a major cause of disability and death in all patient populations. It is estimated that venous thrombosis and pulmonary embolism (PE) are associated with approximately 500,000 hospital admissions in the United States each year.[1] About 250,000 cases of clinically recognized DVT occur each year in patients hospitalized in acute care hospitals in this country, and over 100,000 patients die each year as a result of pulmonary embolism in the United States.[1,2] The magnitude of the problem is felt to be much greater since there is no data available from nonacute care facilities, such as rehabilitation hospitals, where the incidence of PE may be higher.[2]

Clinical risk factors for venous thrombosis include advanced age, obesity, malignant disease, prior thromboembolic disease, immobility, major trauma, and major surgery, particularly those procedures involving the abdomen and lower extremities. Without prophylaxis the incidence of DVT after general surgery is about 25%; it rises to over 50% after total hip replacement, and even higher after total knee reconstruction.[2-4] All patients undergoing elective total joint replacement should receive routine pharmacological prophylaxis against DVT,[1,2,5] unless absolute medical contraindications exist.

Venous thromboembolism may be unrecognized due to the clinically silent nature of the disease. Both deep venous thrombosis and pulmonary embolism manifest few specific symptoms, and the clinical diagnosis is insensitive and unreliable.[2] For this reason, knowledge of specific clinical risk factors in individual patients and awareness of the incidence of DVT in patient categories where the risk has been defined by epidemiological studies should be the primary considerations when thinking of thromboprophylaxis.

There are currently three accepted pharmacologic therapy alternatives for thromboembolic prophylaxis: adjusted-dose unfractionated-heparin,

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low-molecular-weight heparins, and warfarin. Heparin is a heterogenous polysaccharide mixture with an average molecular weight of 12,000 to 15,000 daltons. lts mechanism of action is due to an interaction with antithrombin lll and enzymes of the coagulation pathway including thrombin (factor lla) and factors lXa, Xa, Xla, and Xlla. The activated partial prothrombin time (aPTT) measures the intrinsic clotting system (factors Vlll, IX, Xl, and Xll), as well as the factors in the final common pathway (factors ll, V, and X). Clinically, the aPTT measures the interaction of heparin on the coagulation system. The short duration of the drug's pharmacologic action requires multiple doses per day to achieve maximal efficacy. Consequently, dosing regimens must be individualized according to the aPTT. Because of the constant monitoring that is necessary, the use of adjusted-dose heparin in the outpatient setting is more difficult to implement and has lower patient acceptance than enoxaparin or warfarin. lt is administered subcutaneously.

Enoxaparin is a low-molecular-weight heparin obtained by the depolymerization of a benzyl ester of natural heparin. The average molecular weight of enoxaparin is approximately 4,500 daltons. Compared with heparin, the anti-Xa activity of enoxaparin is equivalent and the anti-lla activity is lower. Due to the limited effect of enoxaparin upon factor lla, routine monitoring of the aPTT is not required in the manner it is with heparin. lt is administered subcutaneously in standard dosing regimes, usually twice a day.

Warfarin interacts with the vitamin K-dependent coagulation factors (ll, VII, lX, and X) and the anticoagulant proteins C and S. Clinically, the prothrombin time (PT) measures the interaction of warfarin on the coagulation system. Numerous factors, alone or in combination, including changes in diet, physical state and concomitant medications, may influence the response of the patient to warfarin therapy. Because warfarin is not always predictable in its antithrombotic or anticoagulant properties, prothrombin time requires careful monitorization. Treatment, therefore, is individualized. lt is administered orally.

Cost-effectiveness and Pharmacoeconomic Models for DVT Prophylaxis

Most experts agree that thromboprophylaxis of any kind is more cost-effective than no prophylaxis or general diagnostic surveillance and selective treatment.[2,3] Several reports support the cost-effectiveness of the various pharmacological approaches in the prevention of venous thromboembolism.[4,6-12] A review of these studies is beyond the scope of this report.

In the recent literature there are primarily two economic models for DVT prophylaxis after total joint replacement with the three pharmacological alternatives accepted today. Bakst[13] reported a pharmacoeconomic comparison between low-dose Warfarin (the dose that maintained prothrombin time (PT) at an international normalization ratio between 2.0 and 3.0), Enoxaparin (30 mg administered twice daily), and fixed-dose Heparin (5,000 Units three times a day). The length of prophylaxis was 7 days for both inpatient and outpatient populations. The variables evaluated included drug costs, laboratory costs (not charges), home care costs, and costs of the treatment of bleeding complications, DVT, and non-fatal PE (the incidence of which was obtained from meta-analysis and individual studies). The results demonstrated that the total cost of Enoxaparin therapy ($341.40 per patient) was less than either Warfarin ($590.26 to $640.50 per patient) or fixed-dose Heparin ($434.77) per patient). Although this report led to the addition of Enoxaparin to the formulary of the Cleveland Clinic (with the proviso that it be restricted to orthopedic surgery), two considerations need to be made about the study. First, from the methodological standpoint, the evaluation of actual costs for some services and charges for other ones may lead to significant differences in the total cost of therapy. Second, from a clinical viewpoint, the short length of treatment, 7 days, does not correlate with the treatment protocols in several clinical trials, prospective studies, and analytic models in which at least 7, and usually 14 days of post-operative prophylaxis were used.[6,14-20] Additionally, recognized experts on venous thromboembolic disease recommend 2 to 3 weeks.[21]

ln June 1996 Carter and Brookfield[22] reported an economic model and outpatient thromboembolic prophylaxis guidelines after orthopedic surgery by comparing Warfarin (5 mg a day) and Enoxaparin (30 mg twice a day). Prophylaxis was started at the time of discharge and continued for 6 weeks. The economic variables included drugs, home care services, and laboratory costs. ln the Warfarin protocol, PT and partial thromboplastin time (PTT) were monitored twice a week for the first 2 weeks, once a week for the following 2 weeks, and once every other week for the balance of a 6-week period, and platelet counts on weeks

1, 2, 3, 4, and 6. In the Enoxaparin protocol no monitoring of PT or PTT was required and platelet counts were monitored at weeks 1 and 2. Costs for professional services were determined by averaging the fees from three home care agencies, therefore representing the perspective of the consumer. Costs of drugs were determined by submitting five dummy claims to insurance companies, hence, representing the perspective of the payer. The results demonstrated that the first 3 weeks of therapy with Enoxaparin ($658.38) cost an almost equivalent amount as the first 3 weeks of Warfarin therapy ($634.76). After 3 weeks of treatment, the cost of Enoxaparin was greater than Warfarin. One important consideration about this study was that it did not consider the cost of thromboembolic prophylaxis during the immediate post-operative period, which can lead to significant differences in the global cost of therapy. The initiation of DVT prophylaxis postoperatively (with either Warfarin or Enoxaparin), and even pre-operatively (with Warfarin) is well documented in previous reports.[4,6,14-20,23,24] Additionally the consideration of the consumer's perspective (actual charge) for some variables, and the payer's perspective (actual reimbursement) for others, increases the confusion with regard to the real overall cost of treatment. Based on these comments this investigator considered both economic models of limited application for the development of practice guidelines in DVT prophylaxis after total joint replacement.

Pharmacoeconomic Study

This study presents a pharmacoeconomic comparison for DVT prophylaxis after total hip and knee arthroplasty between Warfarin and Enoxaparin, started postoperatively, and continued in the outpatient setting. The purpose of this report is twofold: First, to present an economic model that approximates closely to the standards of current orthopedic practice, based on the review of the literature and the most recent recommendations from experts in the field of DVT prophylaxis, and, secondly, to provide physicians, hospital decision-makers, and third-party payers with valid information in order to balance considerations of clinical value and economic impact in patient care management.

Design

1. Drugs evaluated — The Warfarin protocol called for an initial 10 mg dose given post-operatively, to follow with 5 mg per day. This simplification may underestimate the cost of Warfarin because additional costs could be incurred if dosage adjustments and additional monitoring were needed for those patients whose PT and/or PTT levels were not within the desired range. The protocol for Enoxaparin included 30 mg twice a day, starting in the immediate post-operative period. For the purposes of this study it was assumed that the efficacy and safety of either regimen were identical.

2. Length of treatment — Prophylaxis was started within 12 hours post-operatively and continued through the inpatient and outpatient periods, for a total of 15 days. This length of therapy was determined based on the following factors: (A) The peak incidence of DVT has been reported to occur between days 5 and 10 following either total hip or knee replacement surgery,[25] and (B) Although the formal recommendations are 6 weeks of treatment after total knee replacement[5] and no formal agreement exists after total hip arthroplasty, most experts agree that prophylaxis after total joint replacement (hip or knee) should be continued until the patient is spending the majority of his/her day ambulating with or without external aides.[4,18,25] Recognized specialists on DVT prophylaxis recommend 10 to 20 days.[21] Of the total 15 days, the prophylaxis was administered while in the hospital for the first 3 days, followed in the outpatient (home) setting for the remaining 12 days, based on the current average discharge from the hospital (between days 3 through 6).[25]

3. Laboratory Data — For the Warfarin protocol the evaluation included daily PT and PTT during the inpatient stay; PT every 3 days and PTT once a week in the outpatient period; complete blood counts, including platelets (CBCs) were monitored once before discharge, and then once a week in the outpatient setting. Enoxaparin prophylaxis called for CBCs once in the inpatient setting before discharge, then twice (once a week) during the outpatient period. The rationale behind this monitorization protocol was based on the following factors: (A) The close monitorization required in order to detect any post-operative bleeding. (B) Although the PTT is normally used to monitor therapy with unfractioned heparin, a sizable subset of patients (19.3%) on Warfarin prophylaxis are prone to post-operative bleeding (26.3%) due to abnormal elevations of their PTT (greater than 50 seconds), whereas the control PT value is in the desired range. Those patients

Table 1. Warfarin Praphylaxis

	Mean Cost ($)	Cumulative Cast ($)
Inpatient:		
10 mg pa past-ap	2.00 × 5 dases	10.00
5 mg po qd × 3 days		
PT qd × 3 days	31.63 × 3	94.89
PTT qd × 3 days	41.27 × 3	123.81
CBC qd × 3 days	40.26 × 3	120.78
Outpatient:		
5 mg pa qd × 12 days	11.19/12 doses	11.19
PT q 3 days	23.16 × 4	92.64
PTT q week	34.33 × 2	68.66
CBC q week	29.58 × 2	59.16
Home Care q 3 days	97.66 × 4	390.64
		Total: 971.77

po = arally; qd = every day; PT = Prathrambin Time; PTT = Partial Thramboplastin Time; CBC = Camplete Blaad Caunt, including Platelets; q = every.

Table 2. Enaxaparin Praphylaxis

	Mean Cast ($)	Cumulative Cast ($)
Inpatient:		
30 mg s.c. bid × 3 days	37.91 × 6 dases	227.46
CBC × 1 day	40.26	40.26
Outpatient:		
30 mg s.c. bid × 12 days	403.18/24 dases	403.18
CBC q week	29.58 × 2	59.16
Hame Care q week	97.66 × 2	195.32
		Tatal: 925.38

s.c. = subcutaneausly; bid = 2 times a day; CBC = Complete Blaad Caunt, including Platelets; q = every.

demonstrating an abnormal response to warfarin therapy, as manifested by a significant elevation of the PTT, are clearly at an increased risk of post-operative hemorrhage. Based on their study, Paiement et al[26] formally recommended routine monitoring of Warfarin therapy by the PTT as well as the PT in the first 7 to 10 post-operative days. (C) Moderate thrombocytopenia has been reported in 1.9% of patients receiving Enoxaparin, therefore periodic monitoring of CBCs, including platelets, are recommended as a routine procedure.[27]

4. Home Health Services — Included a skilled nursing visit and blood drawing.

Methods

The costs of drugs, laboratory, and home health services represent the consumer's perspective, therefore, they illustrate the actual charges for the respective services supplied (inpatient pharmacy and laboratory, outpatient pharmacy and laboratory, and home care agency). The consideration of drug acquisition costs and providers' specific agreements were disregarded for the purposes of simplification and standardization in this study. This investigator opted for the dollar figure from the consumer's standpoint since it represents the actual cost of medical care called upon society as a whole. Costs for all data variables were determined through surveying three different providers for each service and obtaining the mean value for each category. All providers were located within the Louisville, Kentucky, metropolitan area. Data gathering took place during October 1996.

Results and Conclusions

The results of this economic model (see Tables 1 and 2) indicate that Enoxaparin ($925.38) was slightly less expensive than Warfarin ($971.77) for the prevention of DVT after total joint replacement, when all the costs associated with therapy were considered. Based on these results the small difference in cost should not affect the choice of drugs used; therefore, in this investigator's opinion, clinical factors alone should influence the decision on which prophylactic regimen is to be utilized in each individual patient.

The author encourages the reader to exercise caution when interpreting these results due to the bias introduced with the assumptions that have been made. Additionally, there are also possible questions about the ability to generalize these results to other clinical settings. Notwithstanding these reservations, this economic evaluation supplies valid information for health care providers in the aforementioned community in order to balance clinical and financial considerations in venous thromboembolism prophylaxis after total joint replacement. Further studies in specific clinical settings and individual health care markets may be required to assist in the development of protocols for patient care management.

Discussion

Two important observations need to be kept in mind when analyzing pharmacoeconomic evaluations. First, from the economic standpoint, the rapid changes in healthcare that are taking place today are likely to affect the overall costs of care through the integration of health care services and the development of agreements between

providers, including physicians, hospitals, the pharmaceutical industry, and ancillary services. Second, from the clinical standpoint, using economic models to assist in the development of practice guidelines is a necessary evil in this era of cost-containment. By doing so the medical community runs the risk of placing more emphasis on cost-avoidance than on clinical outcomes. Physicians need to be reminded that treatments should be individualized according to specific clinical risk factors in each patient, and play a key role, along with other professionals, in the development and implementation of universal protocols for medical treatment. This investigator gladly is surprised with the fact that this is already a reality in some parts of the country.[28]

Table 3. Cast af Services by Individual Praviders

1. Haspital A.
   Inpatient Pharmacy: Warfarin 5 mg $1.81
   Enaxaparin 30 mg $25.80
   Outpatient Pharmacy: Warfarin 5 mg × 12 dases $11.88
   Enaxaparin 30 mg × 24 dases $465.12
   Inpatient Labaratary: Prathrambin Time $25.08
   Partial Thrambaplastin Time $27.59
   Complete Blaad Caunt, including Platelets $37.07
2. Haspital B.
   Inpatient Pharmacy: Warfarin 5 mg $2.75
   Enaxaparin 30 mg $57.04
   Outpatient Pharmacy: Warfarin 5 mg × 12 dases $12.57
   Enaxaparin 30 mg × 24 dases $422.82
   Inpatient Labaratary: Prathrambin Time $25.57
   Partial Thrambaplastin Time $47.53
   Complete Blood Caunt, including Platelets $43.89
3. Haspital C.
   Inpatient Pharmacy: Warfarin 5 mg $1.44
   Enaxaparin 30 mg $30.91
   Outpatient Pharmacy: Warfarin 5 mg × 12 dases $9.12
   Enaxaparin 30 mg × 24 dases $321.60
   Inpatient Labaratary: Prathrambin Time $44.26
   Partial Thrambaplastin Time $48.69
   Complete Blood Caunt, including Platelets $39.82
4. Outpatient Labaratary A.
   Prathrambin Time $16.00
   Partial Thrambaplastin Time $20.00
   Complete Blaad Caunt, including Platelets $15.00
5. Outpatient Labaratary B.
   Prathrambin Time $26.25
   Partial Thrambaplastin Time $47.00
   Complete Blaad Caunt, including Platelets $46.25
6. Outpatient Labaratary C.
   Prathrambin Time $27.25
   Partial Thrambaplastin Time $36.00
   Complete Blaad Caunt, including Platelets $27.50
7. Hame Health Agency A.
   Skilled nursing visit and blaad drawing $105.00
8. Hame Health Agency B.
   Skilled nursing visit and blood drawing $98.00
9. Hame Health Agency C.
   Skilled nursing visit and blaad drawing $90.00

ACKNOWLEDGMENT: Representatives from the following institutions were explained in detail the purpose of the information they were asked to provide, and this investigator would like to express his gratitude for their participation in this study. They were all guaranteed that the information they provided would remain confidential and that only the mean values would be included in this report.

- Jewish Hospital: Inpatient/Outpatient Pharmacies, and Inpatient Laboratory
- Norton Hospital: Inpatient/Outpatient Pharmacies, and Inpatient Laboratory
- Univ of Louisville Hospital: Inpatient/Outpatient Pharmacies, and Inpatient Laboratory
- Medical Towers Laboratory
- Laboratory Corporation of America
- SmithKline Beecham Clinical Laboratories
- Caretenders — Home Health Services
- Visiting Nurse Association — Home Care Services
- Olsten Kimberly Quality Care — Home Health Agency

Additionally, I would like to thank Gregory Rash, EdD (Research Director of the Physical Medicine and Rehabilitation Residency Program) for his advice in reviewing this report and for his editing assistance.

References

1. Silver D. An overview of venous thromboembolism prophylaxis. *Am J Surg.* 1991;161(4):537-540.
2. Clagett GP, Anderson FA, Levine MN, Salzman EW, Wheeler HB. Prevention of venous thromboembolism. *Chest.* 1992;102 (Suppl 4):391S–407S.
3. Bergqvist D, Matzsch T. Cost/benefit aspects on thromboprophylaxis. *Haemostasis.* 1993;23(Suppl 1):15-19.
4. Lieberman JR, Geerts WH. Prevention of venous thromboembolism after total hip and knee arthroplasty. *J Bone Joint Surg.* 1994;76(8):1239-1250.
5. D'Ambrosia R, Sculco TP. New perspectives in the prevention of venous thromboembolic disease: Clinical and economic factors. Establishing a universal protocol for deep vein thrombosis following orthopedic surgery: Total knee arthroplasty. *Orthopedics.* 1996;19(Suppl):6-8.
6. Menzin J, Colditz GA, Regan MM, Richner RE, Oster G. Cost-effectiveness of enoxaparin vs low-dose warfarin in the prevention of deep-vein thrombosis after total hip replacement surgery. *Arch Intern Med.* 1995;155(7):757-764.
7. Bergqvist D. Cost-effectiveness of venous thromboembolism prophylaxis in surgery. *Eur J Surg.* 1994;(Suppl)571:49-53.
8. Salzman EW, Davies GC. Prophylaxis of venous thromboembolism: Analysis of cost-effectiveness. *Ann Surg.* 1980;191 (2):207-218.
9. Bergqvist D, Matzsch T, Jendteg S, Lindgren B, Persson U. The cost-effectiveness of prevention of post-operative thromboembolism. *Acta Chir Scand Suppl.* 1990;556:36-41.
10. Oster G, Tuden RL, Colditz GA. A cost-effectiveness analysis of prophylaxis against deep-vein thrombosis in major orthopedic surgery. *JAMA.* 1987;257(2):203-208.
11. Anderson DR, O'Brien BJ, Levine MN, et al. Efficacy and cost of low-molecular-weight heparin compared with standard heparin for the prevention of deep vein thrombosis after total hip arthroplasty. *Ann Intern Med.* 1993;119(11):1105-1112.

12. Paiement GD, Wessinger SJ, Harris WH. Cost-effectiveness of prophylaxis in total hip replacement. *Am J Surg.* 1991;161 (4):519-524.
13. Bakst A. Pharmacoeconomics and the formulary decision-making process. *Hosp Formul.* 1995;42-50.
14. Leclerc JR, Geerts WH, Desjardins L, et al. Prevention of deep vein thrombosis after major knee surgery — A randomized, double-blind trial comparing a low molecular weight heparin fragment (enoxaparin) to placebo. *Thromb Haemost.* 1992;67(4):417-423.
15. Levine MN, Hirsh J, Gent M, et al. Prevention of deep vein thrombosis after elective hip surgery. A randomized trial comparing low molecular weight heparin with standard unfractionated heparin. *Ann Intern Med.* 1991;114(7):545-551.
16. Turpie AG, Levine MN, Hirsh J, et al. A randomized controlled trial of a low-molecular weight heparin (enoxaparin) to prevent deep-vein thrombosis in patients undergoing elective hip surgery. *N Engl J Med.* 1986;315(15):925-929.
17. Amstutz HC, Friscia DA, Dorey F, Carney BT. Warfarin prophylaxis to prevent mortality from pulmonary embolism after total hip replacement. *J Bone Joint Surg.* 1989;71(3):321-326.
18. Harris WH, Salzman EW, Athanasoulis C, Waltman AC, Baum S, DeSanctis RW. Comparison of warfarin, low-molecular-weight dextran, aspirin, and subcutaneous heparin in prevention of venous thromboembolism following total hip replacement. *J Bone Joint Surg.* 1974;56(8):1552-1562.
19. Hull R, Raskob G, Pineo G, et al. A comparison of subcutaneous low-molecular-weight heparin with warfarin sodium for prophylaxis against deep-vein thrombosis after hip or knee implantation. *N Engl J Med.* 1993;329:1370-1376.
20. O'Brien BJ, Anderson DR, Goeree R. Cost-effectiveness of enoxaparin versus warfarin prophylaxis against deep-vein thrombosis after total hip replacement. *Can Med Assoc J.* 1994;150(7):1083-1090.
21. D'Ambrosia R, Colwell CW, Anderson FA, Brox T, et al. New perspectives in the prevention of venous thromboembolic disease: Clinical and economic factors. Question-and-answer session. *Orthopedics.* 1996;19(Suppl):24-25.
22. Carter CA, Brookfield RB. Outpatient thromboembolic prophylaxis following orthopedic surgery: Treatment guidelines and economic analysis. *Manag Care Med.* 1996;May–June:22-27.
23. Colwell CW, Spiro TE, Trowbridge AA, et al. Use of enoxaparin, a low-molecular-weight heparin, and unfractionated heparin for the prevention of deep venous thrombosis after elective hip replacement. *J Bone Joint Surg.* 1994;76(1):3-14.
24. Spiro TE, Johnson GJ, Christie MJ, et al. Efficacy and safety of enoxaparin to prevent deep venous thrombosis after hip replacement surgery. *Ann Intern Med.* 1994;121(2):81-89.
25. D'Ambrosia R, Fitzgerald RH. New perspectives in the prevention of venous thromboembolic disease: Clinical and economic factors. Post-discharge prevention of deep vein thrombosis following total joint replacement. *Orthopedics.* 1996;19(Suppl):15-18.
26. Paiement GD, Bell D, Wessinger SJ, Harris WH. The Otto Aufranc Award Paper. New advances in the prevention, diagnosis, and cost effectiveness of venous thromboembolic disease in patients with total hip replacement. *Hip.* 1987;94-119.
27. *Physicians Desk Reference.* 50th ed. Medical Economics Company. 1996:2020-2022.
28. Prager LO. Doctor-driven utilization controls. *Ann Med News.* 1996;39(40):23.

The Problem With Assumptions

"What the data support is the overwhelming power of the doctor-patient relationship, an inherently non-economic relationship, which creates and nurtures everything that supports and underpins the delivery of health care in this country."

I recently encountered an essay which quoted the philosopher Karl Popper and discussed what he described as "pre-scientific" thinking. In its most simplistic construct, this type of thought involves beginning with a conclusion and then commencing a search for data, which supports that preconceived perspective. The essay strongly argued the fact that too much of our current public discourse involves just this type of thinking. While the examples cited therein were largely geopolitical, much the same argument can be made about the current quality of discussion in the health care arena.

When we listen to claims that health care costs are rising beyond acceptable percentages of GNP and beyond control, an argument is being made that there is a finite demand and supply for health care services. If one begins with this argument, it becomes easier to understand how the argument for capitation, restricted access, and frank rationing of services can be made. One can simply blame excessive provider costs, unfettered pharmaceutical profits, insurance company rapacity, and medical-legal constraints for the excessive costs of care. Yet, if the data are fairly analyzed, the removal of the aforementioned sources of blame only temporarily impacts the overall cost of health care in this country. What the data support is medicine's seemingly limitless capacity to create and implement new and effective medical technology and our society's equally apparent demand for its benefits.

In the political arena, medicine as a profession has frequently spent significant human, political, and economic capital in the defense of specific formulas for physician compensation. The debate pivoted on the conclusion that physicians deserved certain reimbursement levels by virtue of their lengthy education, malpractice exposure, burdensome overhead, and clinical judgement. It became easy for our opponents to counter these arguments by pinpointing the taxpayer subsidization of a large amount of medical education, the relative lack of data supporting much of medical decision-making, the relative levels of physician salaries, and the ability of non-physician providers to fulfill some aspects of the physician's purportedly exclusive role. What the data support is the overwhelming power of the doctor-patient relationship, an inherently non-economic relationship, which creates and nurtures everything that supports and underpins the delivery of health care in this country. When physicans have couched their arguments for or against certain reimbursement policies in the context of its impact on the patient and enlisted patient support for that position ("drive through deliveries," for example), the economic impact to physicians has often been favorable and the impact on patient care has been positive.

In medical education, there has been a long-standing desire to allocate medical specialty training slots to coincide with projected manpower needs. The argument assumes a static delivery system, immutable spectrum of disease, and a limited capacity for physician training. Then we encounter

"What the data support is medicine's seemingly limitless capacity to create and implement new and effective medical technology and our society's equally apparent demand for its benefits."

a system of health care which becomes more and more successfully regionalized and technologically integrated, life expectancy lengthens and HIV disease appears along with an attendant demand for geriatricians and infectious disease specialists, and specialty-trained physicians successfully incorporate new practice techniques and/or retrain in response to technological developments and market pressures. What the data support is the need to select and train the best and brightest candidates possible to confront a turbulent and changing medical future.

As medical students we were challenged to learn to take a history in detail and perform a meticulous physical exam. As residents we developed the capacity to take that database and apply it to patient management. As practitioners we strive to hone the diagnostic elegance and therapeutic acumen required of us to appropriately care for our patients. None of these endeavors involves "pre-scientific" thinking. They require our open minds and hearts to see what is before us and to do what we conclude to be of most benefit to our patients. To the matters confronting our profession today, we should and must apply the same.

Daniel W. Varga, MD

State of the State Alliance

The story I began telling you, when I stood before you almost a year ago at my installation as 73rd President of Kentucky Medical Association Alliance, has grown. It includes what we do at Kentucky Medical Association Alliance. We are caring physicians' spouses who are proactive voices of the Kentucky Medical Association in the community.

This year's story is of a visionary approach for the Focus '97-'98, where we integrated Health Promotion-SAVE, Legislation, and AMA-ERF into a membership development tool.

Focus '97-'98 SAVE is a joint campaign to stomp out violence from our communities since 1995 when Kentucky Medical Alliance joined American Medical Association Alliance. The project SAVE is an acronym for **S**top **A**merica's **V**iolence **E**verywhere. With the help of many generous contributors and supporters—

- Kentucky Medical Association, Public Education Committee
- Kentucky Cabinet for Health Services, Department for Public Health, Frankfort
- Trover Foundation
- Family Advocacy Center — Hopkins County, Health Department
- Pike County Domestic Violence Board
- Southern Medical Association Auxiliary, Health Education
- Donation to Honor State Kentucky PTA Volunteers Where Children Come First
- Perry County
- Donation to Honor KMA Alliance Volunteers Working in Coalition with Organization for Quality Health Care of Children & Families Across the Commonwealth
- AMA Alliance by giving a discount
- All Organized County Alliances

thousands of dollars were raised, a substantial discount was given by American Medical Association Alliance, and a one time large order for the project was placed.

The project provided 80,000 each of "I Can Choose" Booklets and "Hands Are Not For Hitting" Place Mats which were distributed to kindergarten through 3rd grades in the public schools for all organized and some unorganized counties in the state. These two publications are aimed at teaching children conflict resolution skills without resorting to violence.

In the month of March, the Medical Alliance Month/Doctor's Day Month, the above publications were in the hands of children with the help of Alliance members, school health nurses, health coordinators, counselors, teachers, and parents. Three hundred and seventeen public schools in the following counties with K-3 children have received the publications:

Daviess	McCraken
Jefferson	Webster
Perry	Trigg
Caldwell	Christian
Hopkins	McLean
Fayette	Harrison
Pulaski	Muhlenberg
Crittenden	Madison
Henderson	Calloway
Boyd	Ohio
Northern Kentucky	Pike
Todd	Union
Warren	Franklin

Kentucky Medical Association Alliance is represented on the following:

1. Governor's Advisory Council, Kentucky Incentive Project on Substance Abuse Prevention
2. Kentucky Action Executive Committee



Aroona Dave

3. Kentucky Coalition of School Health
4. Kentucky Association of School Health

We were able to organize Madison County Medical Society Alliance and all the members are excited about having SAVE Program in their county schools.

Madison County Medical Society Alliance has invited their prospective members to their membership drive. The counties that have potential to be organized have dues-paying members as their contact people.

Our story was told to the prospective members through our new Membership Brochure. Hundreds of them learned accurately what we do at the Alliance. President of Resident Physicians' Spouse Group was able to attend the AMA Alliance's Leadership Confluence at Drake, Chicago, along with eight county Presidents-Elect.

Our story resounded the Commonwealth of Kentucky, when upon our request, Governor Paul

Patton signed a proclamation declaring October 8th, 1997 SAVE Today day. Our legislative Vice-President, Angie DeWeese, was with almost 60 Alliance Members able to attend "A Day At The Capitol" — a legislative session sponsored by Kentucky Medical Association. A legislation requiring addition of language in marriage license dealing with reduction of domestic violence was introduced in the General Assembly. An Anti-Tobacco Resolution shall be introduced in the Kentucky Medical Association Alliance, House of Delegates.

Many members across the state made membership a major issue and as a result of this effort, we hope to reach our goal. American Medical Association Educational Research Foundation was efficiently put before all concerned by our President-Elect Nominee, Carolyn Daley, and we have a successful story to tell you.

Past years' achievements are the sum of caring, courage, hard work, and cooperation. I commend our Board Members, County President/Presidents-Elect who have shown unusual juggling skills in being able to balance family/social commitments and being volunteers for Kentucky Medical Association Alliance.

We will be concluding the past years' story at the 75th celebration at the Annual Convention, Madisonville, Kentucky, on April 20-22, 1998. Capturing one's hopes and vision and turning it into the reality is what all the members across the state have done this year through all the projects/ programs and public relations in the community. Seminar on Media Violence by nationally known speaker, Dr David Walsh, will be open to area health coordinators, school health nurses, and health providers.

As we leave the legacy of 75 years of excellence for the future leaders, the story of the past year will continue when following officers for 1998-99 are installed by American Medical Association Alliance's Secretary Ann Hansen:

Jan Crase (Mrs James), President
Carolyn Daley (Mrs G.I.), President-Elect
Kathy Cavanaugh (Mrs Kevin), Vice President, Membership Development
Angie DeWeese (Mrs Bob), Vice President, Legislative Affairs
Vicky Borders (Mrs Jack), Vice President, AMA-ERF
Audrey Carter (Mrs Keith), Vice President, Health Promotion
Nancy Bunnell (Mrs Thomas), Secretary, Promotion
Kaye Florence (Mrs Joseph), Treasurer

I recommit my support and cooperation to our future leaders and the future of this organization. As we have told our story to the organizations with whom we have worked in coalition this year, the circle of possibilities has been widened.

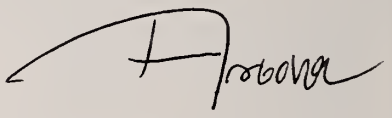
With eternal hope, deep understanding, and proactive attitude, I can say that we are on our way to the next millennium. We are fortunate to have the cooperative and supportive staff and leadership at our parent organization, the American Medical Association Alliance. Our special relationship with Southern Medical Association is most valued.

I would like to give my heartfelt thanks to the members of the Staff of the Kentucky Medical Association, my second family, as I come to the close of my term. They have demonstrated efficiency, understanding, and professionalism. I could not have done it without the encouragement, understanding, and support of my dearest Uday, Nish, Manisha, and Christopher, and my entire medical family.

As I have traveled through the State at county Alliance meetings, I have been overwhelmed by the love, support, and warmth from everyone.

I would be remiss if I did not mention those who came before me for their 'CARING'! My best.

Fondly,



Aroona Dave, President
Kentucky Medical Association Alliance
1997-98

A Real Doctor

I am often approached by medical, legal, and other groups to give public addresses regarding my and my colleagues' practice of forensic pathology, for a certain fascination with all things forensic has been with our society for a long time. Given the high profile nature of many recent murder trials, it should not strike the reader as surprising that everyone from medical associations to bar associations to the Rotary Club wants to have a speaker wax eloquently over a lunch meeting on medical examiner work. Such popular interest is not without precedent; even at the turn of this century, Americans were fascinated, as now, with courtroom procedure and the role of scientific evidence in the prosecution of criminal cases.

We forensic pathologists are, I must declare, an oft-misunderstood lot, not only by the public, but also by our own medical colleagues. Many times I have been called by a high school or college student wanting to know if the course of study to become a medical examiner is one or two years. The disappointment he or she registers is palpable when I reply that after four years of college, four years of medical school, five years of residency training in anatomic and clinical pathology, and a year of fellowship in forensic pathology, one then assumes the sobriquet of medical examiner. The fire and enthusiasm in the young man or woman's voice on the other end of the line often deflates quickly, and hasty good-byes are muttered.

As noted above, many colleagues are not quite sure of what we do either. My two brothers, an obstetrician and pediatric ophthalmologist, are wont to ask, "Well, you know he was shot; why do you have to do an autopsy?" I patiently explain to them, as I have to civic groups as well as agencies in charge of funding the various medical examiner programs with which I have been associated, that the cause of death is only a small part of the postmortem examination, a procedure encompassing everything from scene investigation to autopsy and beyond, with collation of investigative and medical data in an attempt to not only explain the cause of death, but also the manner of death (natural, accident, suicide, homicide), mechanisms of death, and circumstances surrounding death. Often, procurement of evidence, such as a firearm projectile or fingernail scrapings, can be the linchpin of the successful prosecution of a murder. I'm fond of telling legislators that since a murder trial can cost over $1,000,000 to stage,[1] it behooves the medical examiner's office to have available adequate resources. It is a battle that many medical examiner programs fight continuously, for death is not a favorite topic of discussion in many political offices, and as one member of congress told me years ago, "Dead people don't vote." My immediate retort: "Their relatives *do*, however." It is an argument that sometimes is accepted, sometimes not. We are fortunate in Kentucky to have the stewardship of the Division of Medical Examiner Services in capable hands, hands which articulately procure for the Commonwealth the necessary resources for performing our necessary duties.

On an early Autumn Saturday, one of those clear, bright days in which the beauty of the Bluegrass is enough to bring a tear to the eye, I had three cases to perform from various parts of Central and Eastern Kentucky, our office's bailiwick. The three were quite representative of the caseload with which we deal. The first examination of the day was an accidental death, a young teenager who was driving home drunk from a Friday night party and lost control of his automobile, killing himself and severely injuring another. The second was a victim of homicide, a middle-aged woman whose partner beat her with a blunt object. The third was a suicide, a young woman, distraught over recent losses, who shot herself in the chest. All in all, it was not an unusual day for our office in Frankfort, where we perform approximately 800 postmortem examinations per year.

I have often proclaimed, to the consternation of some and the delight of others, that were it not for drunk driving and easy access to firearms, our caseload would be half its current level. Put another way by my Vermont friend, author Archer Mayor, originator of the Joe Gunther mystery series, "All your work comes down to the 'Four L's': Liquor, Loot, Lunacy and Lust." Well put, it is an aphorism which is as easily applied to policework, emergency departments, and trauma surgery, all sister professions which have much common ground with forensic pathology.

I love my profession, a claim which may seem morbid to some, but I must profess that while a certain intellectual pleasure is gained from performing a good dissection, it is the autopsy as springboard that interests me most; that is, it is what we do with the autopsy that matters. We gather data regarding those things that cause morbidity and mortality for Kentuckians, we procure evidence for court, we teach, we contribute to health research; in other words, we are physicians dedicated to the public's health. I used to bristle when one of my brothers or colleagues would say, "Why don't you want to be a 'real' doctor."[2,3] Happy with my choice, I now laugh, knowing that while the patients I directly serve are deceased, I also serve a broad constituency of relatives of the deceased, medical professionals, legal professionals, organ procurement agencies, and others. I routinely speak with more numbers and a wider variety of individuals than I did when I was a clinical physician, and I often find myself in a unique position to offer that most precious of gifts that any physician, any human being, can give: peace of mind. Peace of mind, whether it comes from telling the mother of an

infant dead of Sudden Infant Death Syndrome that there was nothing she did or didn't do that could have changed things, to telling the relative of a murder victim that, given my examination of the deceased, I can say with certainty that he or she did not suffer. The look of palpable relief on the faces of these loved ones is a sight to behold, and such interactions can often be a reaffirmation of our basic reasons for desiring to become physicians in the first place.

We are but cogs, albeit important ones, in the machinery of the investigation of sudden, unexpected, and violent death which befalls citizens of our Commonwealth. As is true of any specialty in medicine, however, it is not being part of any machinery that offers the truest joy in one's profession, rather, it is the personal communication: whether with families of the deceased, fellow medical colleagues, law enforcement officials, attorneys (be they prosecution or defense), organ procurement officials, or any other interested party, it is through this human connection that I feel my truest fulfillment as a physician, or, in the words of my two brothers, as "a real doctor."

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References

1. Personal communication, Thomas R. Keith, District Attorney, 21st Prosecutorial District, State of North Carolina.
2. Inoshita T. The education of a pathologist. *Ann Intern Med.* 1992;117:608.
3. Davis GJ, Lantz PE. Pathologists are doctors. *Ann Intern Med.* 1993;118:575.

WHEN SMOKERS QUIT

Within 20 minutes of smoking that last cigarette, the body begins a series of changes that continues for years.

20 MINUTES
- Blood pressure drops to normal
- Pulse rate drops to normal
- Body temperature of hands and feet increases to normal

8 HOURS
- Carbon monoxide level in blood drops to normal
- Oxygen level in blood increases to normal

24 HOURS
- Chance of heart attack decreases

48 HOURS
- Nerve endings start regrowing
- Ability to smell and taste is enhanced

2 WEEKS to 3 MONTHS
- Circulation improves
- Walking becomes easier
- Lung function increases up to 30 percent

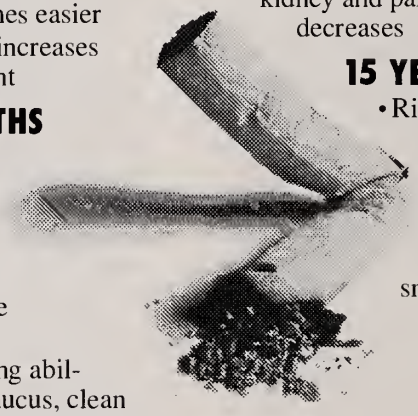
1 to 9 MONTHS
- Coughing, sinus congestion, fatigue, shortness of breath decrease
- Cilia regrow in lungs, increasing ability to handle mucus, clean the lungs, reduce infection
- Body's overall energy increases

1 YEAR
- Excess risk of coronary heart disease is half that of a smoker

5 YEARS
- Lung cancer death rate for average former smoker (one pack a day) decreases by almost half
- Stroke risk is reduced to that of a nonsmoker 5-15 years after quitting
- Risk of cancer of the mouth, throat and esophagus is half that of a smoker's

10 YEARS
- Lung cancer death rate similar to that of nonsmokers
- Precancerous cells are replaced
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decreases

15 YEARS
- Risk of coronary heart disease is that of a nonsmoker



Source: American Cancer Society; Centers for Disease Control and Prevention

Sutton's Law

Jane M. Orient, MD, and Linda J. Wright

Hacienda Publishing, Inc
PO Box 13648
Macon, GA 31208-3648
1997; 299 pp, $21.95

Reviewing a novel instead of non-fiction changes the pace, if not the importance of the message. Mixing medicine, murder, morality and money, not only the m's come in staccato, but also the story races through this small book with fury.

EquaCare as the corporate entity becomes the malefactor, while the heroine in white smock works through her internship with bodies falling in front of her. Her science reads through the charted data, failing to equate the numbers with the outcome. While the DRG profiles and cost effectiveness reports documented the good and bad economic doctors, other physicians took turns at abetting the plot, or trying to uncover what was wrong. Mix in some interpersonal gamesmanship and a few intimacies for the sex interest, the reader lives the words coming out with anticipation.

The subliminal, but all too obvious message is that managed care is potentially nefarious, and that today's fiction is tomorrow's reality.

With mystery and plentiful intrigue, this novel would stand on its own for some reading evening, but the messenger screams that there is a higher meaning.

Medical Warrior: Fighting Corporate Socialized Medicine

Miguel A. Faria, Jr, MD

Hacienda Publishing
PO Box 13648
Macon, GA 31208-3648
1st edition, 209 pp, $23.95

Packed into this small book, five parts use an historical and political perspective to examine modern medicine. Really a series of essays, this information boils out of Dr Faria's passionate effort to explain the current predicaments and travails for the physician in practice. His aim is for the heart of the doctor as well as the brain. Past cultures, from the Greek and Roman days, to the more recent industrial age, can compare to the assaults on medicine now. If deteriorating medical ethics, placing the corporate welfare ahead of the patient's well being predominates, then medicine will evolve from a benevolent, humane occupation, to a robotic builder of economic powerhouses.

Reflecting the criticism that those who emasculate government and its programs are self centered, Dr Faria answers that government corrupts the doctor patient relationship and flourishes by expanding control over the people. That we the people do not know what is good for us and need protection from medical practitioners makes this book reading a necessity, if this misconception perpetuates itself.

Each part of the book, starting with "Lessons from History," "Medical Ecology," "Towards Collectivism in Medicine," "The Role of Public Health," and "Managed Care, Corporate Socialized Medicine and Medical Ethics" explains this decay, suggesting that political immorality and soft moral fiber catalyze this reaction.

Those in private practice medicine and their present and future patients may read this book to stimulate, exacerbate, and finally construct an approach to fighting their enemies. A bibliography, although brief and selective, continues the reader's indoctrination. With an index busy in names and references, this work may also be handy for future work.

Stephen Z. Smith, MD
Book Review Author

PEOPLE

Kenneth S. DeSimone, MD, a Greensburg surgeon, received the first annual Norton Hospital Outreach Physician Award during the Annual Adult Services Symposium.

The award recognizes Dr DeSimone's selfless practice of medicine, meritorious service to the community, consistent advocacy for outstanding quality patient care and dedication, and support of the ongoing medical education process.

John S. Spratt, MD, University of Louisville professor of surgery and health systems, is a retired captain in the Naval Reserve and a clinical professor of surgery at the Uniformed Services University. Dr Spratt recently attended the 52nd Annual Meeting of the Armed Forces' Society of Medical Consultants at Uniformed Services University. The society was founded after World War II to support the maintenance of high quality in military medicine.

UPDATES

Health Kentucky, Inc Receives National Award

Health Kentucky, Inc received the sixth annual Monroe E. Trout Premier Cares Award on February 5, 1998, during Premier's annual Governance Education Conference in Orlando, Florida. The award, which carries a $50,000 cash prize, recognizes an exemplary effort that has made health services accessible to the medically under served.

J. Scott Judy, executive vice president of Health Kentucky, said, "This national recognition is for all the generous health care providers involved in the Kentucky Physicians Care network. They are on the front lines, assuring that needy Kentuckians receive health care. We're glad they are receiving some deserved national recognition."

Health Kentucky, Inc is a non-profit, educational and charitable organization designed to help needy Kentuckians obtain access to quality health care. Formed in 1984 as the Kentucky Health Care Access Foundation, Health Kentucky, Inc currently sponsors the Kentucky Physicians Care network (KPC). This statewide "safety net" of care provides no cost health care services to uninsured Kentuckians with incomes below the federal poverty level. Originally offering hospital and physician services, the network consisting of volunteer health care providers has been expanded to include dental, pharmaceutical, home health, and hospice care at no charge to eligible participants. All components of the network are endorsed and co-sponsored by the respective state trade or professional association.

KPC has provided an estimated 300,000 patient and physician contacts estimated at $3.7 million. The total estimate for the physician, dental, and pharmaceutical services donated since 1985 is $5.1 million. In fact, KPC has been so successful that at least three other states, including South Carolina, Georgia, and Arkansas have replicated "Kentucky's model" statewide, while 45 other projects in 26 states have used the model.

Governor Paul E. Patton complimented the work of the organization by saying. "The Commonwealth of Kentucky is very fortunate and grateful for Health Kentucky's commitment to provide health care access to this state's medically under served. Through its 12 years of service, this noble task has been successful in improving the lives of indigent Kentuckians."

The Monroe E. Trout Premier Cares Award is sponsored by Premier, the largest health care alliance enterprise in the United States, with more than 240 owner systems that own or operate some 700 institutions and have affiliations with another 1,000 hospitals. This national award is named in honor of Monroe E. Trout, MD, retired chairman and chief executive officer of American Healthcare Systems, which in 1996 merged with Premier Health Alliance and The Sun Health Alliance to form Premier.

Donald C. Barton, MD, a family physician in Corbin, Kentucky, and president of Health Kentucky, spoke about the KPC program. "To our knowledge no one who has applied and qualified for the program has ever been denied care," he said. "In 12 years of service, that is a remarkable accomplishment."

Those who are uninsured, in need of health care, and do not qualify for Medicaid or Medicare may call 1-800-633-8100 to obtain information about being certified eligible for the Kentucky Physicians Care Program.

3-D Glasses Help Surgeons Look Inside the Body

Virtual reality is all the rage in some game centers. The 3-D glasses similar to those associated with the games now allow surgeons to operate inside the body without opening up the patient's chest.

University of Louisville heart surgeon **Laman A. Gray, MD,** uses the glasses in some heart valve-replacement surgeries. The glasses are connected to tiny cameras and lights, which are inserted to the site of the surgery through small incisions. Dr Gray says the images projected into the glasses are far superior to those projected onto a screen, which has been the common medium for such procedures.

The glasses allow doctors to perform intricate procedures without fully opening the body, dramatically

reducing recovery time and risk of infection, he says.

Plastic Screws Eliminate Need for Second Surgeries

Orthopedic surgeons commonly use metal screws to hold together broken bones. University of Louisville faculty now are using plastic screws that offer several benefits — including eliminating the need for a second surgery to remove the screws.

The University reports that unless removed, the metal screws stay with a patient for life. The plastic screws dissolve and are absorbed into the bloodstream, and bone grows back in the area where the screws had been placed.

Orthopedist **David Seligson, MD,** says since the plastic screws are gone, the chance for late infection is reduced, a factor of particular benefit to patients suffering from immune system problems.

Pap Smears Still May be Best for Finding Cervical Cancer

Two new tests may help spot cervical cancer that otherwise might be missed. But the initial Pap smear still is the best way to test for the disease, says a University of Louisville doctor.

Dennis M. O'Connor, MD, says patients can request the two new tests, PAPNET and ThinPrep. Both methods are effective and probably a good idea for patients at risk for cervical cancer, such as young, sexually active women who have infrequent check-ups. However, women who aren't considered at high risk and who see their doctor regularly probably don't need the additional tests, he says, and a recent study of military women and dependents, published in the *Journal of the American Medical Association*, confirmed that opinion, finding PAPNET offered little benefit to the women, who tend to be screened yearly.

Ironically, the women who would benefit most from the rescreening tests probably are least likely to request them. That may change once insurance companies start to cover the tests, Dr O'Connor said.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Victor L Zirilli MD — R
PO Box 1537, Glasgow, 42142
1981, U of Texas, Galveston

Boyle

Peter F Ballard MD — OTO
516 Popplewell Rd, Danville, 40422-9405
1977, U of Kentucky

Christian

Ruxandra M D Mares MD — P
PO Box 2200, Hopkinsville, 42241
1971, U of Bucharest

Fulton

Thomas J McDonald MD — OBG
2002 Holiday Lane Ste 200, Fulton, 42041
1997, Texas Col of Osteopathic Med

Hopkins

Roderick H MacGregor MD — FP
200 Clinic Dr, Madisonville, 42431
1973, Dalhouse U, Canada

Jefferson

Nancy Kubiak MD — IM
1603 Greensbrook Pl, Louisville, 40245
1991, Baylor Col of Med

Robert William Sweetman MD — PD
723 Winding Oaks Trl, Louisville, 40223
1988, U of Health Science, N Chicago

Kenton

Jordan C Hsu MD — PD
2865 Chancellor Dr Ste 225, Crestview Hills, 41017
1993, Duke

Knox

Charles V Stargel MD — FP
PO Box 1150, Barbourville, 40906
1990, George Washington U

Madison

Julia Ellen Richerson MD — PD
210 Layne Ct Apt C3, Berea, 40403
1993, U of Kentucky

Perry

Rizwan Ali MD — P
PO Box 7191, Hazard, 41701
1989, Dow, Pakistan

Pulaski

John C Rodrigues MD — PUD
118C Tradepark Dr, Somerset, 42503-3427
1982, Topiwala National, India

Rowan

Christian F Weigel MD — IM
234 Medical Cir, Morehead, 40351-1191
1981, St Louis U

Whitley

Glenn M Uber DO — FP
80 Woods Point, Corbin, 40701
1991, Kirksville Col of Osteopathy

In Training

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DEATHS

Richard L. Roth, MD
Louisville
1926-1998

Richard L. Roth, MD, a retired neurologist, died February 16, 1998. Dr Roth was a 1952 graduate of the University of Louisville School of Medicine and a life member of KMA.

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AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

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Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

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Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

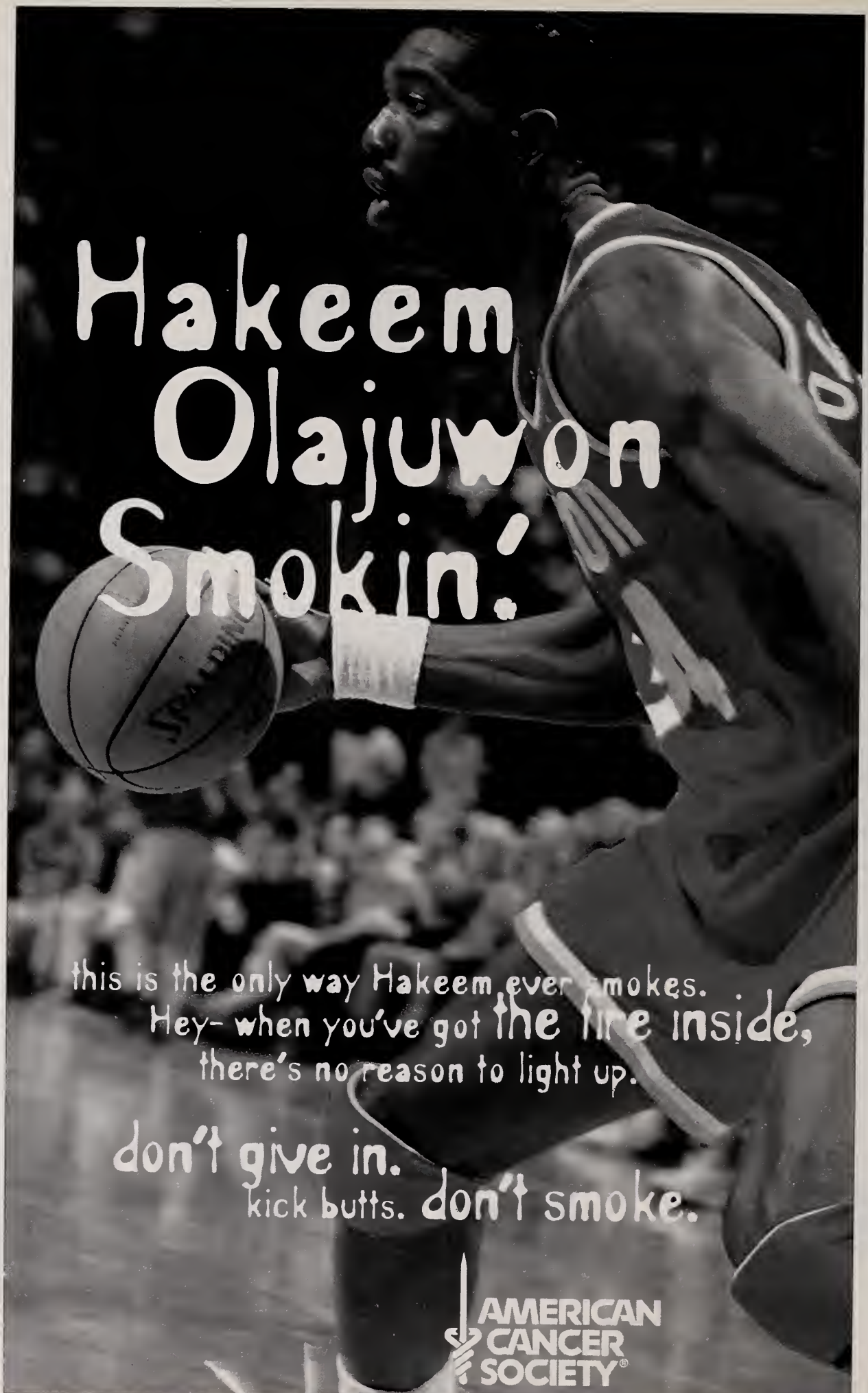
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Please fill in and mail to: KMA, Attn: Awards Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222-6301

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American Cancer Society 154, 160

American Heart Association 158

Baptist Healthcare Society 161

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Louisville, KY 40222-6301

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1998 Annual Meeting

Commonwealth Convention Center, Louisville, KY
September 21-23

1. Title of exhibit _____

2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____

3. Institution if other than exhibitor _____

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   (The draped booth has 4 ′ side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____

   (Table 2 ′ deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____

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6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
4965 US Hwy 42, Ste 2000
Louisville, KY 40222-6301

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 30, 1998.

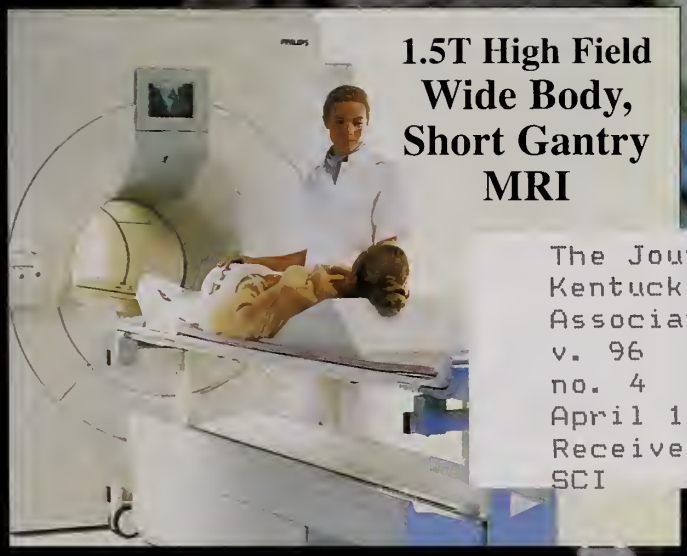
- **COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.**
- **KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.**
- **Exhibit must be dismantled and removed by 8:00 PM, Wednesday, September 23, 1998.**
- **Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.**

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

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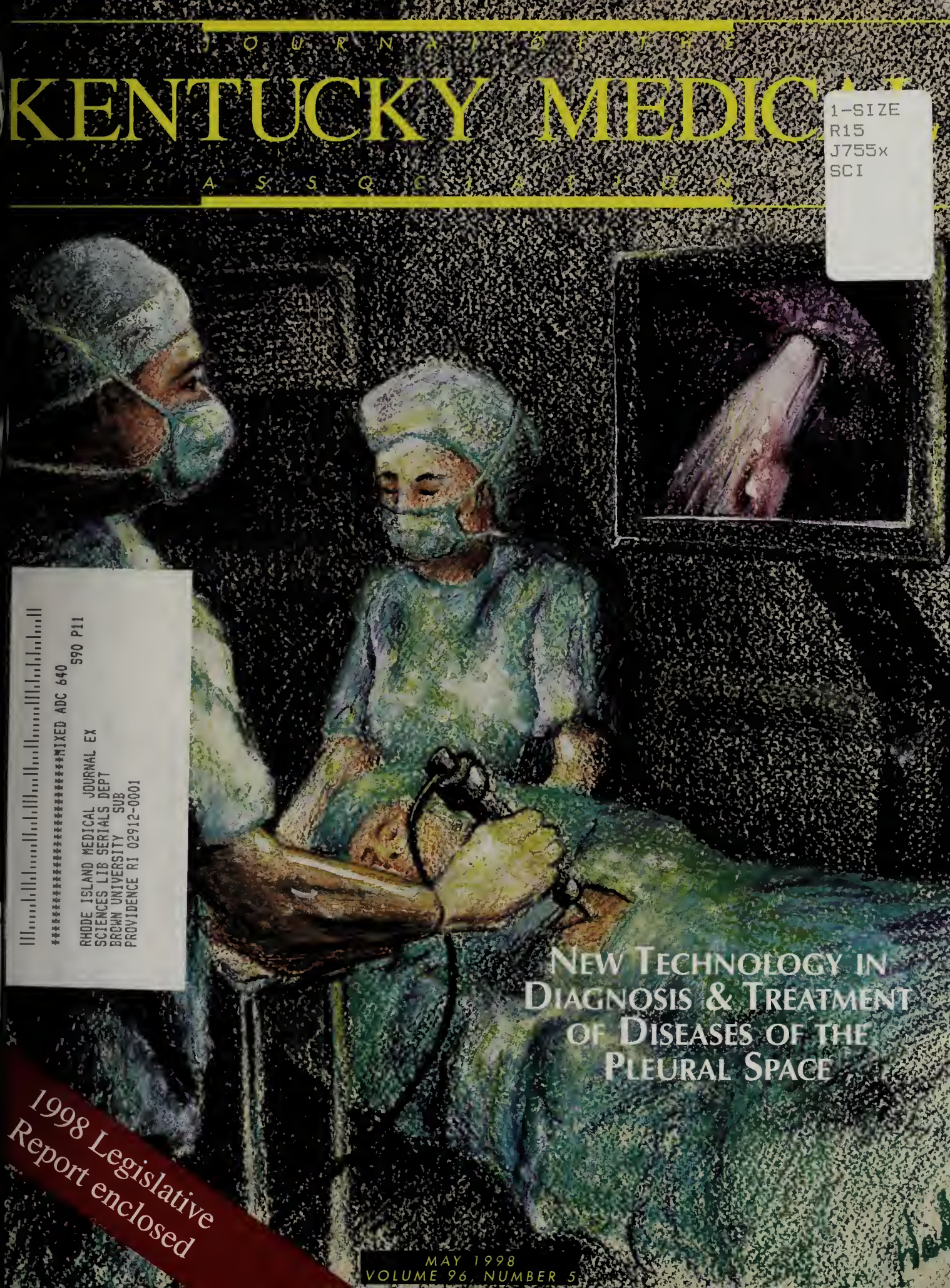


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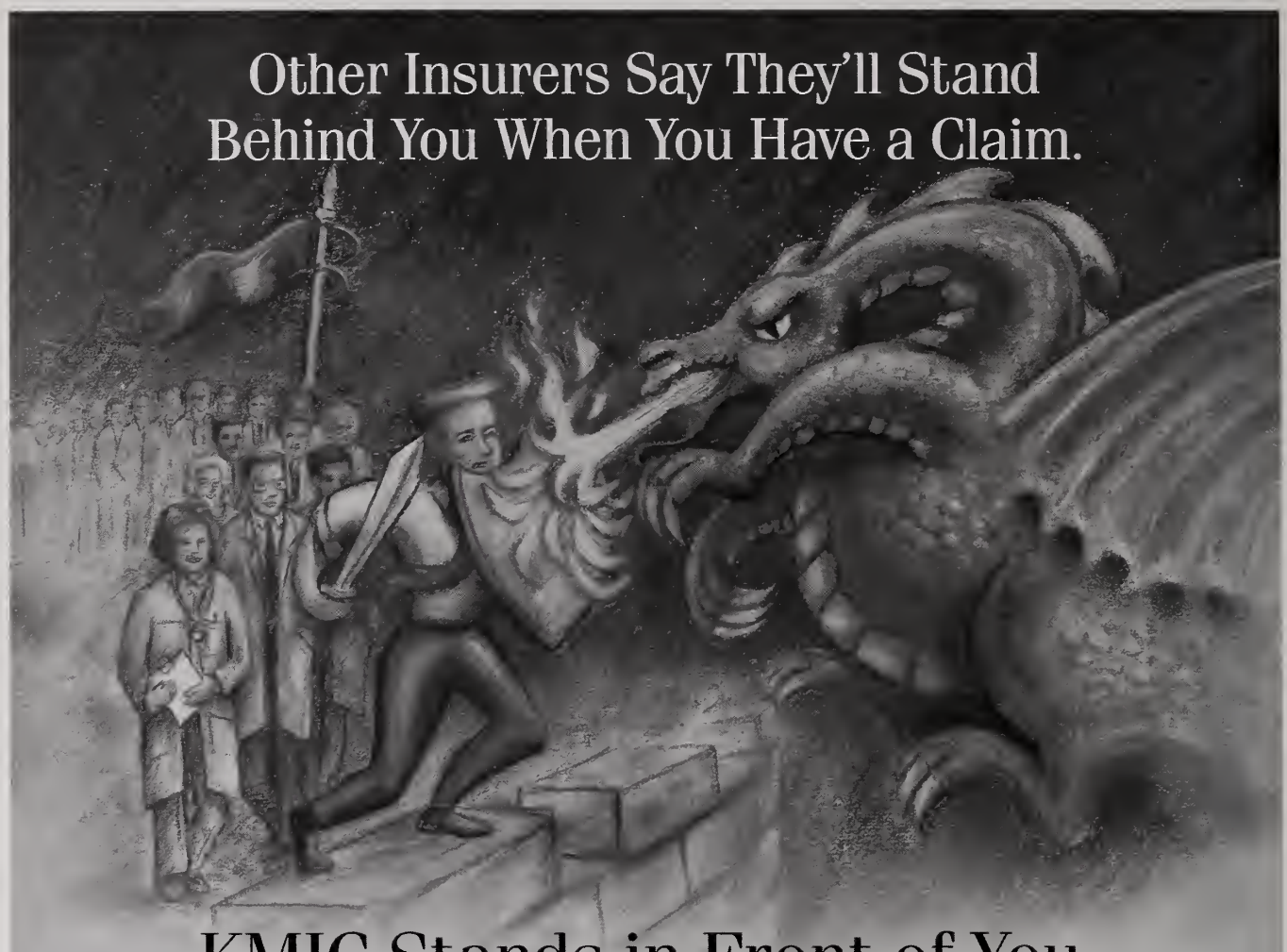
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New Technology in Diagnosis & Treatment of Diseases of the Pleural Space

1998 Legislative Report enclosed

MAY 1998
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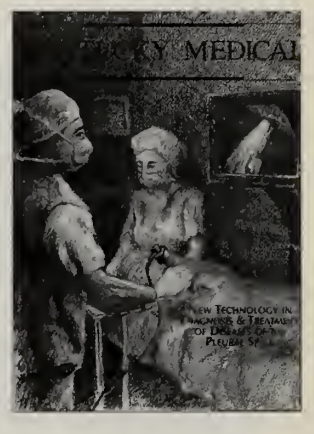
JOURNAL OF THE

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VOLUME 96, NUMBER 5 MAY 1998

COVER STORY	New Technology in Diagnosis and Treatment of Diseases of the Pleural Space *Eddy H. Carrillo, MD; Robert W. Linker, MD; J. David Richardson, MD*	**174**
SCIENTIFIC	Pulmonary Function Testing: Detection of Invalid Performance *Sandra Schuldheisz, MD; Barbara A. Phillips, MD, MSPH: David T. R. Berry, PhD*	**183**
SPECIAL ARTICLE	Which Medical School Applicants Will Become Generalists or Rural-Based Physicians? *Stephen W. Looney, PhD; Richard D. Blondell, MD; Janice R. Gagel, MSN; Margaret W. Pentecost, MAT*	**189**
EDITORIAL	The Drugstore *A. Evan Overstreet, MD, Editor*	**195**
ASSOCIATION	*Monitoring Medicine*	**171**
	Harry W. Carloss, MD, Nominated KMA President-Elect	**199**
	Fraud & Abuse Audits Underway	**201**
	KMA Awards Nomination Form	**188**
	Scientific Exhibits Application	**182**
	News	**200**
DEPARTMENTS	President's Page	**169**
	Advertisers' Guide	**206**
	Alliance Page	**196**
	Classifieds	**205**
	Information for Authors	**181**
	Letter to the Editor	**194**



COVER:
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THE 1998 KMA LEGISLATIVE REPORT IS FEATURED IN THIS ISSUE — LOOK FOR SPECIAL PULL-OUT SECTION FOLLOWING PAGE 186!

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Feeding the Hand That Bites You



Donald R. Stephens, MD

Approximately 25 years ago, insurers and physicians, concerned with the explosion of non-physician practitioners and recognizing growing demands upon the health delivery systems, recommended that licensure of practitioners be halted. Studies indicated that costs are not reduced by expanding the practitioner base, and in fact give impetus to rising health costs. Subsequently, federal and state governments began prohibiting direct reimbursement to non licensed practitioners. However, certification was encouraged.

Non physician groups countered with a five step incremental legislative approach. Not all groups sought all five steps.

(1) Certification
(2) Licensure with mandatory continuing education
(3) Independent practice
(4) Direct reimbursement
(5) Prescribing privileges

The ability of rabbits to procreate takes a backseat when it comes to health practitioners. Beginning in the late 70s on up through the 1996 Kentucky General Assembly, a host of practitioners lobbied the legislature for recognition or practice expansion including: Athletic Trainers, Audiologists, Chiropractors, Clinical Social Workers, Dieticians, Emergency Medical Technicians, Hearing Aid Specialists, Marriage and Family Counselors, Massage Therapists, Mental Health Counselors, Mid-level Practitioners (yes, there exists such a practitioner in Kentucky law), Lay Midwives, Nutritionists, Nurses including Registered Nurses, Advanced Registered Nurse Practitioners, Nurse Anesthetists, Nurse Assistants, Home Health Nurses, Nurse Midwives, Occupational Therapists, Ophthalmic Dispensers, Opticians, Optometrists, Paramedics, Pharmacists, Pharmacy Assistants, Physician Assistants, Physical Therapists, Podiatrists, Professional Counselors, Psychologists, Respiratory Therapists, School Psychologists, Social Workers, Speech Pathologists, and Radiological Technicians.

"The beat goes on." During the 1998 Session a new group of practitioners sought to join the ever growing throng. New groups included Alternative/Non Conventional Physicians, Acupuncturists, Clinical Exercise Physiologists, Naturopathists, Clinical Nurse Specialists, Oriental Health Practitioners, and Pastoral Counselors. Well established groups including Athletic Trainers, Marriage and Family Counselors, Advanced Registered Nurse Practitioners, Pharmacists, Occupational Therapists, Optometrists, and Physician Assistants aspired to expand or alter their practice acts.

Traditional arguments for establishment or expansion of practitioners was based on physician shortage, enhanced access, and reduced costs. However, increased physician supply, better roads, and modern communications have to a large extent addressed most of these

"We are not opposed to professionalism among non physicians. This discussion is about patient care. Only finite resources are available for medical care. Managed care and increasing administrative costs to keep HMOs and other entities afloat will absorb every single additional health care dollar government and business can gin up."

"The most disturbing element comes from well intentioned physician colleagues. During the 1998 Session, KMA was lobbied by physicians to support practice expansion of several groups."

issues. While physician shortages exist in isolated rural areas and inner cities, over supply of physicians should soon eliminate even these concerns.

In 1994 the Kentucky Nursing Association listed ARNP practice locations "by county." Practice location of ARNPs was then compared to Kentucky counties considered "critical" by the Rural Kentucky Medical Scholarship Fund. In 18 of 28 critical counties there were zero (0) ARNPs practicing in those counties. Only 10 of 252 ARNPs or approximately 4% served in critical areas. In fact, 34% (86 of 256) of ARNPs practiced in Jefferson and Fayette counties. Physician Assistants are just as unlikely to practice in rural areas. According to May 1996 Board of Medical Licensure statistics, PAs practiced in 11 of 28 critical counties. In May 1996, 103 of 262 Kentucky PAs practiced in Jefferson and Fayette counties.

As business and government grapple with rising medical costs, the growth of non physician practitioners needs to be studied. In the 1997 Federal Budget, Nurse Practitioners' and Physician Assistants' reimbursement was increased to 85% of Physician fees. While physicians absorbed the brunt of Medicare reimbursement reductions, ARNPs, PAs, Optometrists, and Chiropractors received hefty increases. Kentucky's experience with Medicaid and the growth of expenditures for non physician services further enforces these concerns.

The most disturbing element comes from well intentioned physician colleagues. During the 1998 Session, KMA was lobbied by physicians to support practice expansion of several groups including Marriage and Family Counselors and Athletic Trainers. In addition we received letters from physicians urging KMA to support reimbursement for RNs serving as Assistants at Surgery.

We are not opposed to professionalism among non physicians. This discussion is about patient care. Only finite resources are available for medical care. Managed care and increasing administrative costs to keep HMOs and other entities afloat will absorb every single additional health care dollar government and business can gin up. We stand at the crossroads where physicians may find themselves in a raging battle with a united force of non physician practitioners fighting for dwindling reimbursement dollars.

So, take seriously the growth and expansion of non physician practitioners, its effect upon patient care, and the future of medical practice. Ask yourself—Are physicians over trained and over educated in an era of mass changes in technology and the manner in which medicine is practiced? These are simply perspectives of a country doctor who still believes in the necessity of medical school supported by extensive and intensive residency training, high quality medical care, and the expenditure of the medical dollar in a wise and patient oriented manner.

Donald R. Stephens, MD
KMA President-Elect

NEWS FOR KENTUCKY PHYSICIANS

National Legislative Committee Report

Donald C. Barton MD, Chair

The AMA has established several legislative issues as priority for the 105th Congress:

- Health care quality and patient protection
- Fiscal year 1999 budget
- Fraud and Abuse
- Private Contracting
- Physician self referral
- Tobacco

Patient protection is a hot topic on both state and federal levels. KMA succeeded in developing and adopting an extensive package of patient protection and provider fairness legislation during the 1998 Kentucky General Assembly. While that's extremely good news, the bad news is that due to an exemption provided under the ERISA law, the legislation does not apply to all the people in Kentucky. Presently, the federal ERISA law exempts, "self insured" plans from most state insurance provisions. The exemption self insured plans enjoy from state mandates and other provisions prohibits the State Insurance Commissioner from intervening on behalf of the patient. Perhaps the most insidious exemption, which has been upheld by the highest court in the land, provides that ERISA plans are not liable for medical decision making. Representative Norwood of Georgia, a dentist, has introduced HR 2960, which is cosponsored by over 200 Representatives. HR 2960 removes that exemption and allows a patient or their family to sue self insured managed care plans when decisions lead to injury or death. This provision, commonly referred to as the "Texas Law" has been introduced in several states. The Texas Law is under attack in the federal courts. As you recall, KMA adopted a Resolution in the 1997 KMA House of Delegates last year supporting that concept. In fact, Senator Ernesto Scorsone of Lexington introduced the bill in the '98 Session. On the downside, AMA is greatly concerned with a provision in HR 2960 which expands the Any Willing Provider concept and in turn the practices of nonphysician providers.

Dr Ganske of Iowa has re-introduced his bill banning gag clauses and gag practices. As you recall, Republican leadership killed Ganske's bill last Session due to opposition from the Chamber of Commerce and big business. Senator Kyl has a companion bill in the Senate. Other legislation, including President Clinton's proposal, has extensive Patient Protections. At the AMA Leadership Conference in March, Speaker Gingrich and President Clinton both indicated that some form of patient protection would be adopted during this Session of Congress.

The Administration's 1999 Budget continues Clinton's quest for a single payer or national health system, incrementally, or piece by piece. As you recall, his 1998 budget called for the Child Health Insurance Program which was adopted. Clinton proposes expansion of Medicare by subsidizing Medicare premiums for seniors aged 62-65, who repay the subsidies through a surcharge on their monthly Part B premium after turning 65. Seniors aged 55-62 would be allowed to "buy into" Medicare under certain circumstances. The AMA is extremely concerned with these provisions, especially when the long term solvency of Medicare is already a major budgetary issue.

While the proposed budget does not call for frontal assaults on physician payments, it uses a back door approach by proposing user fees for filing nonelectronic claims, duplicate or unprocessable claims, registration and renewal participation in Medicare, and fees for certification and recertification surveys. The accumulative total of user fees would exceed $207 million — all coming out of physicians' pockets — one way or the other.

The issue of Fraud and Abuse has become politically popular among both Republicans and Democrats. The issue has been expanded to such an extent that there is little distinction between inadvertent errors and legitimate medical judgments versus true fraud. The facts belie some of the charges thrown out in the political arena. Physicians and other professionals reimbursed

under Part B won 70% of the appeals when carriers initially denied their claims. Presently, criminal penalties do not apply unless a provider had a specific intent to violate the law. AMA continues to urge Congress to oppose any attempt to repeal the "knowing and willful" intent standard. The False Claims Act has been used to pursue a number of high profile investigations. While hospitals have been the focus for these investigations, physicians will probably be the next target. AMA is supporting efforts to establish reasonable thresholds for triggering the application of the False Claim Act.

The AMA continues to work with Senator Kyl to enact the right of patients to privately contract for health care. The White House, Democrats, and especially the AARP, are opposing the Kyl proposal. Other issues in which AMA is concentrating include changes in the federal physician self-referral laws (Stark I and II). On the regulatory front, AMA is opposed to HCFA's proposed rule that would eliminate the requirement that nurse anesthetists be supervised by a physician in all approved hospitals and ambulatory surgical facilities where nurse anesthetists can practice independently. Of course, the E/M Guidelines continue to be a major issue with AMA and special meetings with all specialty groups are planned. The AMA obtained a 6 month delay in implementation of these guidelines.

In conclusion, it is obvious that there is much work to be done. It was recently reported that AMA topped the list — the number one organization in the US in terms of spending for lobbying by organizations or associations. The AMA expended $8.5 million from January to June 1997 in lobbying the Congress and Administration proposals. The report noted that AMA employs over two dozen lobbyists. All of this representation which takes place on behalf of every physician in the US, is accomplished by a relatively small group of physicians. In a recent report, it was noted that less than 31% of practicing physicians are members of AMA. In Kentucky we do a little bit better, by holding at about a 50% level. Obviously medicine's ability to negotiate is hampered when 69% of physicians refuse to bear part of the burden. Representation by specialty and subspecialty groups continues to grow as the "balkanization" of medicine undermines medicine's voice. The divide and conquer concept worked in other industrialized nations and obviously is working in the US. National consensus must take place within the physician community, especially among warring medical specialties and subspecialties if we are to survive.



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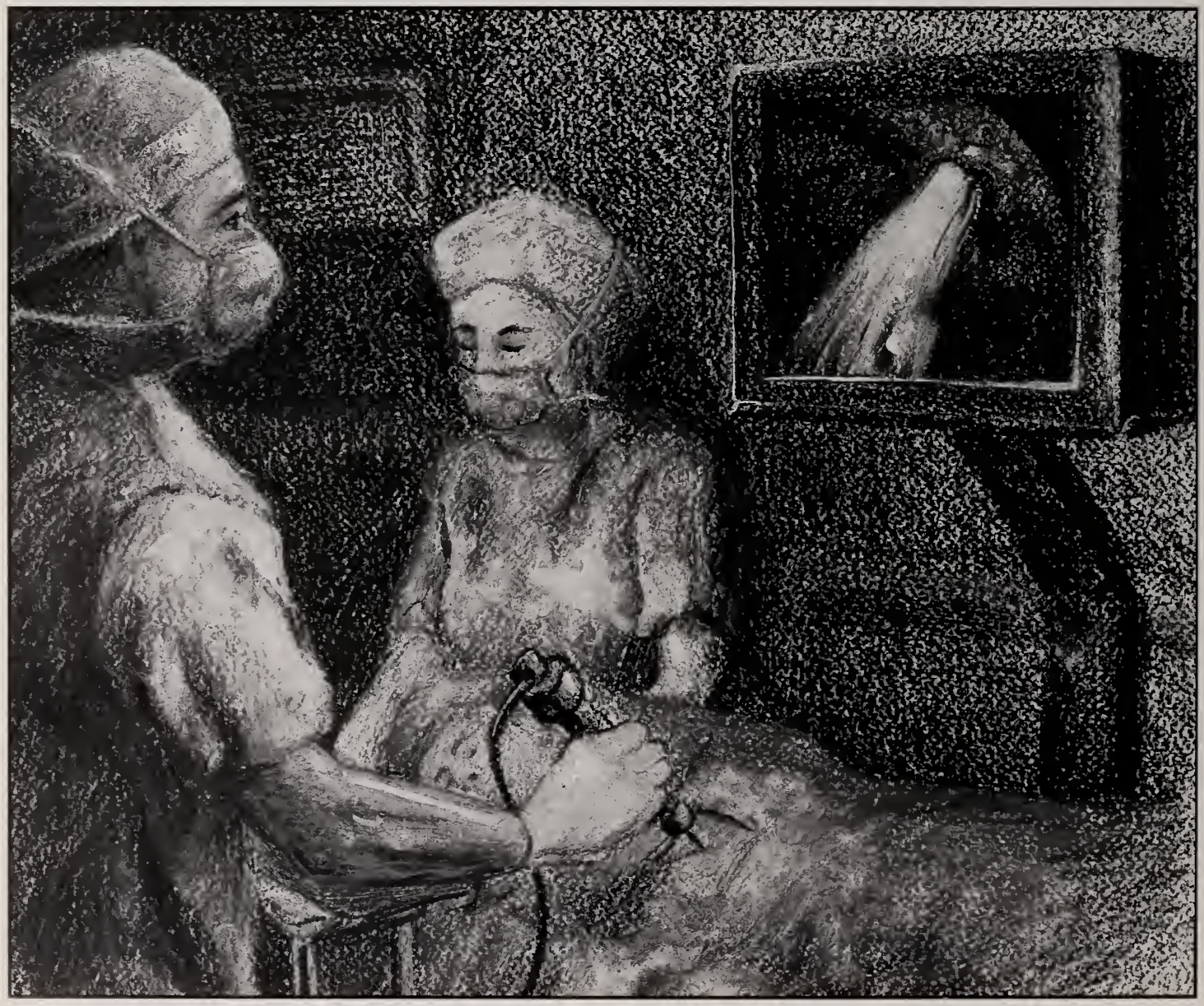
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New Technology in Diagnosis and Treatment of Diseases of the Pleural Space

Eddy H. Carrillo, MD; Robert W. Linker, MD; J. David Richardson, MD



Recent developments in video camera technology, new instruments, and advanced surgical techniques have increased the importance of video-assisted thoracoscopic surgery (VATS). Currently, VATS offers a new approach in the diagnosis and treatment of many thoracic conditions previously treated only by standard thoracotomy. In our experience, VATS is a safe, reliable, and effective alternative to thoracic surgery. With further improvements and refinements in video imaging and endoscopic instruments, more procedures will be technically feasible. The long-term results of VATS compared to open thoracotomy will require extensive follow up and prospective trials to determine its true value.

Video-assisted thoracoscopic surgery (VATS) has assumed a major role in and become the standard of care for a variety of surgical diseases of the chest. Initially used primarily for diagnostic purposes, VATS now is used as an alternative to thoracotomy. Recent reports advocate VATS as the modality of choice for diagnosing and treating selected pathologic conditions of the chest.[1-4]

Hans Christian Jacobaeus[5] is credited with the first clinical application of thoracoscopy at the University of Stockholm in 1922, when he reported his experience in the management of pleural adhesions, biopsy of thoracic malignancies, drainage of empyemas, and the diagnosis and treatment of tuberculous pleural effusions. Thoracoscopy did not gain early widespread acceptance in the United States, and leading thoracic surgeons such as John Alexander actually discouraged use of the procedure.[3] However, thoracoscopy continued to be used mainly in Europe and South America as an aid for lung collapse therapy in patients with tuberculosis. With the advent of successful antituberculosis chemotherapy, the use of thoracoscopy dwindled. Renewed interest was generated by Branco,[6] who in 1946 described its value in patients with hemothorax secondary to penetrating injuries. In the 1970s and 1980s, other authors[7-9] described the value of thoracoscopy and established its role in the diagnosis of diaphragmatic injuries after penetrating thoracoabdominal injuries. In the last 5 years, the use of thoracoscopy has been fostered by the rapid development of laparoscopy, the advent of simplified endoscopic techniques, and improved video equipment and increased familiarity with the technique and equipment.

This review focuses on the recent advances in VATS. We will define the indications, benefits, and limitations of this technique in the diagnosis and treatment of diseases of the pleural space. The role of VATS in the diagnosis and treatment of thoracic injuries will not be discussed; it has been previously reported by this and other institutions and currently is accepted as the modality of choice for the diagnosis and treatment of many patients with thoracic injuries.[10-17]

Operative Setting, Technique, and Equipment

The operating team should be familiar with standard thoracic surgical procedures before attempting VATS. Thoracoscopy should be performed in the operating room with the patient under general anesthesia. A double-lumen endotracheal tube should be used for airway control to optimize exposure with one-lung ventilation after collapse of the ipsilateral lung. Arterial blood pressure, arterial oxygen saturation (SaO_2), end-tidal capnography ($Petco_2$), and electrical cardiac activity should be routinely monitored. Since most VATS procedures are completed in under 1 hour, short-acting intravenous anesthetics may be used to enhance the effect of inhalational anesthetics and to facilitate extubation at the completion of the procedure.

Once airway control has been achieved, the patient is placed in the corresponding full lateral decubitus or modified lateral position and secured to the operating table with a thoracic support device ("bean bag"). The ipsilateral arm is flexed 90° at the shoulder and the elbow is supported in an arm stand. The arm is then secured to allow motion that facilitates exposure and avoid injury during retraction (Fig 1).[3,10] Any torque of the thoracoscope against the intercostal spaces should be avoided.[18] This is extremely important in female patients, as well as in individuals with small frames. To facilitate viewing, we use a side-view thoracoscope (30°). To minimize trauma, we have used smaller thoracoscopes (5 mm). We use the anterior axillary line for placement of the thoracoscope and retrieval of specimens, because the anterior intercostal spaces are wider. Proper positioning of the patient and the endoscopic equipment and instruments is extremely important to ensure adequate visualization of the thoracic cavity and enable an open thoracotomy to be performed, if required. Always, the patient is prepared and draped as for full thoracotomy. The basic

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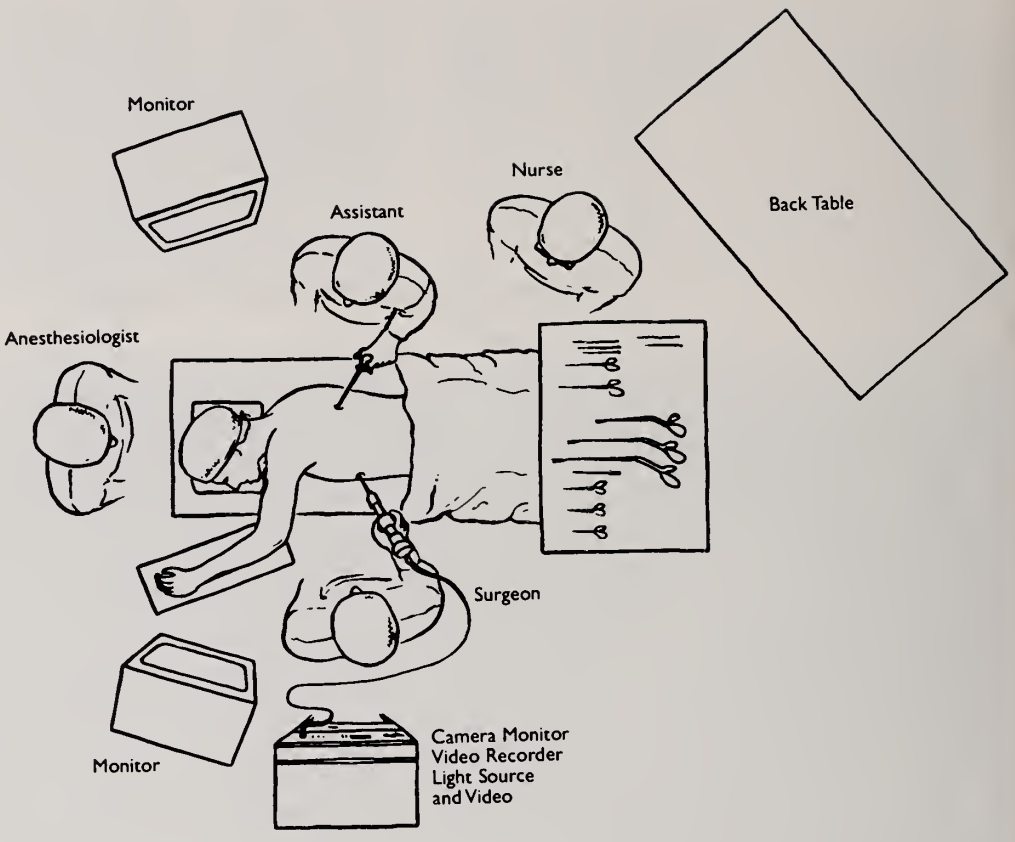


Fig 1— Operating room set up for VATS and orientation of the patient and video equipment. (With permission from Carrillo EH, Heniford BT, Etoch SW, Polk HC Jr, Miller DL, Miller FB, Richardson JD. Video-thoracic surgery in trauma patients. J Am Coll Surg. *1997;184:316-324).*

operative setting and instruments used during VATS are summarized in the Table.

Initiating the Procedure

The VATS procedure is begun by choosing an appropriate intercostal space for insertion of the video thoracoscope. The initial access site should facilitate visualization of the lesion and allow adequate distance for instrument manipulation. Posterior lesions are approached through a slightly anterior intercostal space access site; anterior lesions are approached through posterior axillary intercostal space sites. A preoperative review of the chest x-ray and computed tomography (CT) scans will facilitate both the three-dimensional location of the lesion within the hemithorax and the decision about which intercostal spaces are appropriate to place viewing and operating ports.[3] The table should be flexed in a 30° "jackknife" position to open the intercostal spaces, which facilitates the introduction of instruments into the thoracic cavity, and minimizes post-VATS intercostal neuritis. Initial digital exploration is used to rule out local pleural adhesions and avoid pulmonary injury (Fig 2).

Table 1. Basic Operative Setting and Instruments Used During VATS

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Endascapic retractars
Standard surgical suctian instruments
Endascapic staplers and clip appliers
Straight and curved ring farceps
Thoracostamy chest tubes and water seals

VATS = Video-assisted thoracoscopic surgery.

Orientation During VATS

Using the "baseball diamond" concept for triangulation of the instruments and thoracoscope for strategic visibility and manipulation of the

target lesion will facilitate the orientation of the surgeon, endoscopic instruments, camera, thoracic lesion, and video monitor during VATS procedures. The surgeon, camera, and instruments should be pointed in the same direction, toward the lesion. The video monitor is placed so that surgeon, camera, lesion, and screen are all aligned (Fig 3). This will avoid awkward handling of instruments, due to the "mirror imaging" that results when the instruments are pointed toward the video endoscope.

Specimen Removal

A potential problem encountered with VATS is the removal of infected or malignant tissues from the thoracic cavity. These specimens should always be removed within a plastic container. To avoid contamination, we prefer to use one of the commercially available plastic-sleeved devices introduced through one of the intercostal entry sites. Larger specimens can be placed in a bowel bag, with one of the intercostal working incisions extended 3 to 4 cm without rib spreading, to allow extraction of the specimen.

Upon completion of the procedures, a chest tube thoracostomy is routinely performed under direct vision through one of the working incisions. The remaining wounds are inspected from within the chest for bleeding and then closed in layers.

Patient Selection and Indications for VATS

VATS has been shown to be a safe, reliable, and useful technique.[1-4,10-13] Since lung deflation is a key component of the technique, VATS is contraindicated in patients with inability to tolerate single lung ventilation. Caution should be used in patients with an obliterated pleural cavity secondary to infection or previous surgery, history of bleeding diathesis, and moderate-to-severe obstructive pulmonary disease. VATS has no role in the management of patients in unstable condition or in whom there are clear indications for an open thoracotomy.

Diagnostic and Therapeutic Applications

Pulmonary Nodules and Infiltrates

Thoracoscopic wedge resection is well suited for the evaluation of pulmonary nodules and diffuse pulmonary infiltrates, especially in immunocompromised patients. After insertion of the thoracoscope, the nodule or the area of maximal infiltration is identified. It is then grasped with regular ring forceps inserted through a separate incision. Through a third incision, one or two applications of an Endostapler (Endo-GIA®, United States Surgical Corporation, Norwalk,CT) are fired to perform a wedge resection of the involved lung parenchyma.

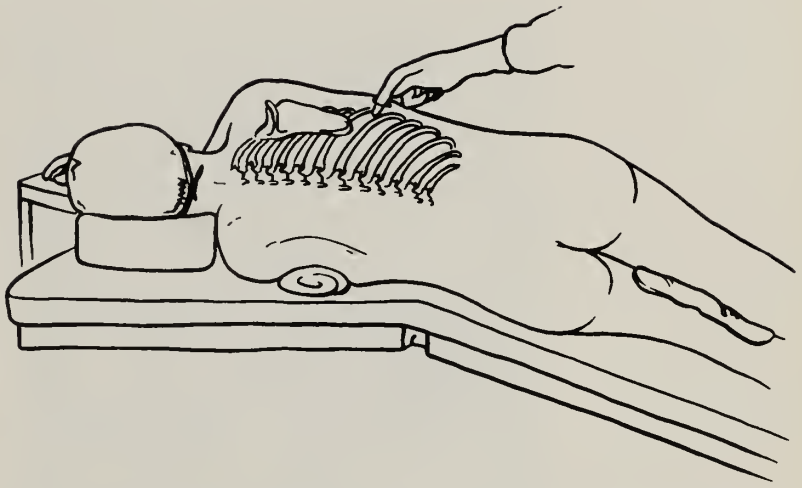


Fig 2— Proper positioning of the patient and initial digital exploration of the pleural space. (With permission from Carrillo EH, Heniford BT, Etoch SW, Polk HC Jr, Miller DL, Miller FB, Richardson JD. Video-thoracic surgery in trauma patients. J Am Coll Surg. 1997;184:316-324).

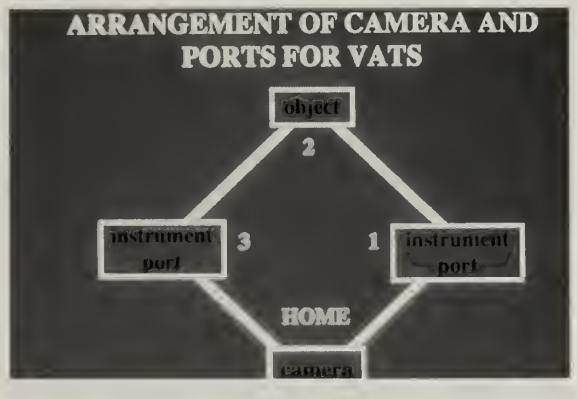


Fig 3— "Baseball diamond" concept for placement of the instruments and thoracoscope for orientation and for adequate visualization of the target pathology.

Pleural Effusions and Retained Thoracic Collections

Thoracoscopy has been shown to be an excellent technique for diagnosis and treatment of subacute, recurrent, and chronic pleural effusions.[2] It also

has been used successfully in the treatment of patients with chylothorax.[19] It is most useful for patients in whom pleurodesis will be performed simultaneously, and in those who have undergone unsuccessful pleural biopsies. VATS has been reported to be 100% accurate in determining the cause of the pleural effusion.[1] The awareness of retained thoracic collections after trauma or pulmonary diseases has increased with the widespread use of new imaging techniques, especially CT scan of the chest. In a review of our experience with 25 patients who underwent VATS for drainage of retained collections after trauma, we found that in 19 patients (76%) the collections were successfully drained. However, the technique was 100% successful when used less than 7 days after injury, and in those patients without evidence of thoracic infection.[11] Given this, we now use VATS in patients with retained post-traumatic hemothoraces as early as 48 hours after hospital admission, when conventional therapy has failed.

If patients with empyema are chosen for this technique, they ideally should be in the early transitional phase (fibrinopurulent stage). In patients with more organized collections, gentle dissection and peeling with sponge sticks and ring forceps usually allows the rind to be removed from the visceral and parietal pleuras, completely releasing the trapped lung. All the debris and necrotic tissue are removed and washed out with warm saline or antibiotic solution.[4,11] Always, a sample of fluid is collected for microbiological assessment.

Spontaneous or Persistent Post-Traumatic Pneumothorax

Currently, VATS has been shown to be the technique of choice for spontaneous pneumothorax as well as for persistent post-traumatic pneumothorax.[1-4,12,20] Preoperative CT of the chest is extremely useful to document the extent of parenchymal disease (Fig 4), since endostapling is not a good option in patients with extensive parenchymal involvement.[12,20]

In general, the source of the pneumothorax usually is identified; otherwise, VATS pleurodesis can be used to control small air leaks.[12,20] Our technique entails investigating the apex of the lung first to identify an active leaking bleb or bullae. If the site is not identified initially, the anesthesiologist is asked to partially release the occluding clamp of the double-lumen endotracheal tube. Warm saline is introduced in the thoracic cavity to identify the source of the air leak. Once the source is identified, an endostapler is fired at the base. In some patients, the use of endoligatures is required to shrink the base of the bullae, facilitating the placement of the endostapler. Lesions deep within the pulmonary parenchyma can be difficult to resect using endostaplers alone, and in these circumstances the use of neodymium-ytrium aluminum garnet (Nd: YAG) laser can spare unnecessary resection of normal pulmonary tissue. In post-traumatic pneumothorax, we do not perform pleurodesis routinely; however, in spontaneous pneumothorax, evidence suggests the value of this technique.[1,4,12,20]

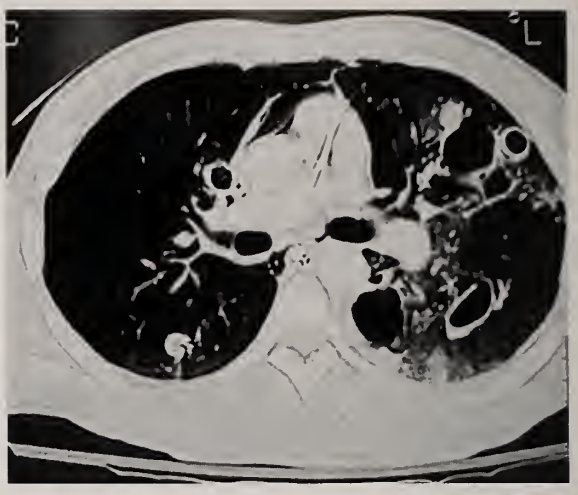


Fig 4— Computed tomography (CT) scan of the chest in a patient with spontaneous pneumothorax and extensive bilateral bullous disease.

Assessment of Mediastinal Structures and Resection of Mediastinal Tumors

Thoracoscopy offers an excellent view of the mediastinum in the left side of the chest. In the right side, usually there is more mediastinal fat, which makes dissection and identification of structures more difficult. VATS may be used as an adjunct to cervical mediastinoscopy for the staging of low mediastinal lymph nodes and as an alternative to the Chamberlain anterior mediastinotomy to assess the aorticopulmonary window and subazygous lymph node regions.[3]

Mediastinal dissection usually is simple, unless there is gross invasion by a tumor. Benign tumors can generally be removed with gentle traction and dissection with careful hemostasis. Most tumors can be removed easily through an extended manipulation incision. While VATS also offers an excellent alternative for biopsies and

staging of some malignant masses, we are very hesitant to perform VATS procedures for resection of documented malignancies, because it does not enable us to determine the extent of invasion.

Esophageal Surgery

Experience with thoracoscopy for several esophageal procedures such as myotomy for achalasia,[21] removal of benign tumors and cysts,[22,23] thoracoscopic antireflux surgery,[24] esophagectomy[3,4] and management of esophageal perforations is limited but growing.

Esophageal myotomy and truncal vagotomy are performed through the left side of the chest in the distal esophagus. The myotomy extends from the level of the inferior pulmonary ligament to 1 cm past the esophagogastric junction. Surgery in the distal esophagus requires that all instruments are directed toward the hiatus, and that the monitors are placed at the foot of the table to give the operators in-line orientation and prevent reversal of the image or "mirror viewing" (Fig 5). A 40 to 48 F Maloney esophageal dilator is introduced into the esophagus to facilitate the dissection during the myotomy. A flexible gastroscope can also be used to stent, transilluminate, and insufflate the esophagus to ensure mucosal integrity during the dissection. Diluted methylene blue can be used at the end of the myotomy to document any esophageal perforation.

Thoracoscopic esophagectomy and intrathoracic stapled esophagogastric anastomosis has been described for treatment of esophageal tumors.[4] We have found this technique to be more useful for assisted esophagectomies when a cervical anastomosis is performed. The patient is placed in the left lateral position. The thoracoscope is placed in the posterior axillary line, two separate ports are placed in the anterior axillary line for lung retraction, and two additional incisions (manipulation channels) are placed in the midaxillary line. The initial dissection is started away from the tumor, after the mediastinal pleura is bluntly and sharply dissected. Grasping the esophagus facilitates the dissection. Electrocautery or surgical clips are utilized for hemostasis. The placement of umbilical tapes at each end of the esophagus during the laparotomy and cervical exploration also facilitates manipulation of the esophagus.

In esophageal perforations, surgical repair of the perforation remains the treatment of choice. However, in selected patients, VATS may have a role as an initial technique for irrigation of the pleural cavity, with placement of drains under thoracoscopic guidance while the patient is stabilized. A definitive repair is attempted at a later date.

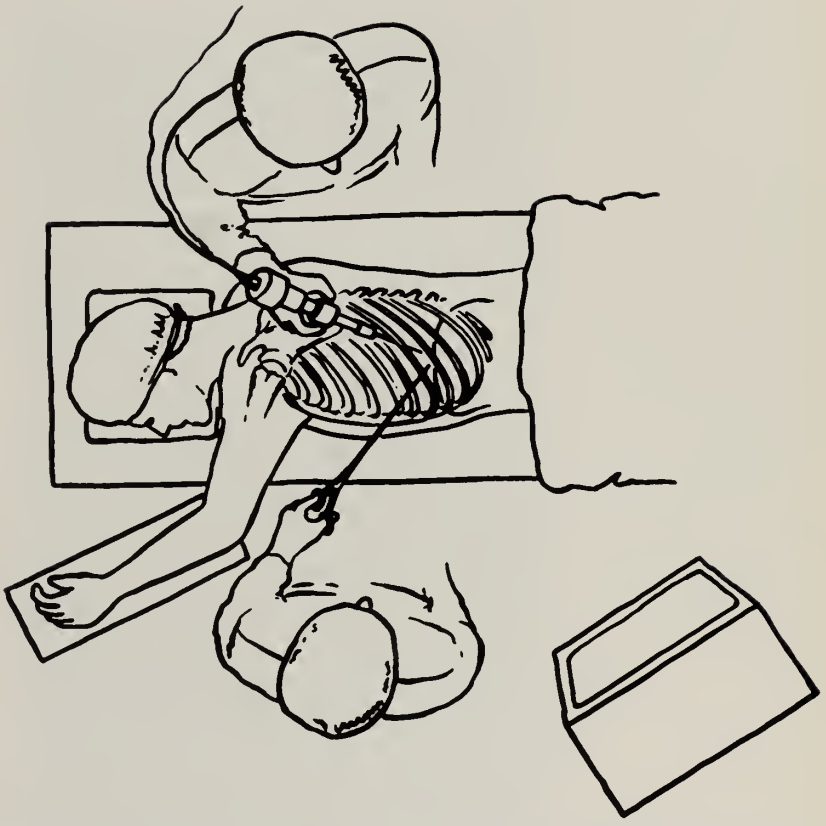


Fig 5— Positioning of the monitor during evaluation of the diaphragm and distal esophageal surgery. (With permission from Carrillo EH, Heniford BT, Etoch SW, Polk HC Jr, Miller DL, Miller FB, Richardson JD. Video-thoracic surgery in trauma patients. J Am Coll Surg. 1997;184:316-324).

Thoracic Sympathectomy

Thoracic sympathectomy for pain control or ulcer healing has been used for some vasospastic conditions (eg, Raynaud's disease, Buerger's disease). Measuring the skin temperature before and after the procedure will document the success of the sympathectomy. During the dissection, excision of stellate ganglions are avoided to prevent Horner's syndrome, a reported complication of this technique.[1]

Pericardial Window and Pericardiectomy

The most important technical detail of this procedure is to avoid injury to the phrenic nerve, which should be routinely identified and main-

tained under visualization throughout the procedure. In patients with pericardial tamponade or effusion, a small stab incision is initially made and subsequently extended along the vertical axis, if needed.[4] In patients with traumatic pericardial ruptures, the pericardial rent usually is extended to a completion pericardiotomy to avoid cardiac herniation and subsequent strangulation.[25] In patients requiring bilateral pericardiectomy for constrictive pericarditis, the left and right sides are resected as in an open procedure, with dissection that avoids injury to the coronary vessels or phrenic nerve.

Lobectomy and Pulmonary Resections

Pulmonary resections, particularly in the periphery of the lung, are easily accomplished. Pulmonary lobectomies usually require additional ports to facilitate exposure and dissection of the pulmonary lobe. It is easier through an extended manipulation incision to introduce standard instruments and proceed with the dissection and resection through this approach.[3,4] In patients with documented and resectable lung carcinomas, the value and benefits of VATS thoracoscopy has not been completely defined, and prospective studies will be needed before this technique can be proposed as a reasonable alternative to an open thoracotomy. However, it is a technically feasible option that can be exercised in selected patients.

Complications of VATS

Although thoracoscopy has been shown to be a safe technique, occasional complications can be expected. The most common complications include chest wall bleeding at the site of the incisions, lung lacerations, intercostal neuritis, and neuroma formation secondary to the use of screwing trocar ports, or from excessive levering of the thoracoscopic instruments.[10,18] Complications from anesthesia are related to the placement of the double lumen endotracheal tube and ventilation of the patient, including hypercarbia, hypoxia and, occasionally, cardiac arrhythmias. Most often, these are corrected after resumption of bilateral lung ventilation. Careful monitoring of the patient should always be part of a VATS procedure.

Future Applications

Video-assisted thoracoscopy is slowly gaining acceptance in the diagnosis and treatment of thoracic diseases, and its use appears to be increasing, as more reports indicate its feasibility and safety. Soon, the clinical use of endoscopic ultrasound, three-dimensional imaging, improvement in endoscopic instruments and the development of a thoracoscope with working channels may very well expand the indications for VATS.

Credentialing and monitoring the results of this technique through the appropriate organizations is extremely important, both to maintain standards and avoid the uncontrolled proliferation of VATS with no quality control. Also, more complex procedures should be studied scientifically through well-designed prospective clinical trials.

In summary, the initial enthusiasm for VATS has been replaced by critical evaluation of its role in comparison to standard surgical thoracotomy. We believe that VATS is safe, reliable, and an effective and excellent alternative to open thoracotomy. When used properly, it will not compromise the patient's recovery and survival, and the cosmetic results and recovery of the patient are superior to an open thoracotomy. Our experience has been that VATS is truly a minimally invasive endoscopic surgery, only slightly more invasive than tube thoracostomy.

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References

1. Yim APC, Ho JKS, Chung SS, et al. One hundred and sixty-three consecutive video thoracoscopic procedures: the Hong Kong experience. *Aust N Z J Surg.* 1994;64:671-675.
2. Salo JA. The role of videothorascopy in the diagnosis and treatment of chest diseases. *Ann Med.* 1994;26:401-404.
3. Keenan RJ, Landreneau RJ, McKneally MF. Video-assisted thoracic surgery. In: Pearson FG, Deslauriers J, Ginsberg RJ, et al, eds. *Thoracic Surgery.* 1st ed, New York, NY: Churchill Livingstone; 1995:131-140.
4. Liu HP, Chang CH, Lin PJ, Hsieh HC, Chang JP, Hsieh MJ. Video-assisted thoracic surgery. The Chang Gung experience. *J Thoracic Cardiovasc Surg.* 1994;108:834-840.
5. Jacobaeus HC. The practical importance of thoracoscopy in surgery of the chest. *Surg Gynecol Obstet.* 1922;34:289-293.
6. Branco JMC. Thoracoscopy as a method of exploration in penetrating injuries of the chest. *Dis Chest.* 1946;12:330-335.
7. Jackson AM, Ferreira AA. Thoracoscopy as an aid to the diagnosis of diaphragmatic injury in penetrating wounds of the lower chest. A preliminary report. *Injury.* 1976;7:213-217.
8. Jones JW, Kitahama A, Webb WR, McSwain N. Emergency thoracoscopy: A logical approach to chest trauma management. *J Trauma.* 1981;21:280-284.
9. Adamthwaite DN. Penetrating injuries of the diaphragm. *Injury.* 1982;14:151-158.
10. Carrillo EH, Heniford BT, Etoch SW, et al. Video-assisted thoracic surgery in trauma patients. *J Am Coll Surg.* 1997; 184:316-324.

11. Heniford BT, Carrillo EH, Spain DA, Sosa JL, Fulton RL, Richardson JD. The role of thoracoscopy in the management of retained thoracic collections after trauma. *Ann Thorac Surg.* 1997;63:940-943.
12. Carrillo EH, Schmacht DC, Gable DR, et al. Thoracoscopy in the management of persistent post-traumatic pneumothorax. *J Am Coll Surg.* In press.
13. Sosa JL, Puente I, Lemasters L, et al. Videothoracoscopy in trauma: Early experience. *J Laparoendosc Surg.* 1994;4:295-300.
14. Ochsner MG, Rozycki GS, Lucente F, Wherry DC, Champion HR. Prospective evaluation of thoracoscopy for diagnosing diaphragmatic injury in thoracoabdominal trauma: A preliminary report. *J Trauma.* 1993;34:704-710.
15. Mancini M, Smith LM, Nein A, Buechter KJ. Early evacuation of clotted blood in hemothorax using thoracoscopy: Case reports. *J Trauma.* 1993;34:144-147.
16. Graeber GM, Jones DR. The role of thoracoscopy in thoracic trauma. *Ann Thorac Surg.* 1993;56:646-648.
17. Ivatury RR, Ochsner MG, Simon R, Lowery RC. Cavitary endoscopy. In: Ivatury RR, Cayten CG, eds. *The Textbook of Penetrating Trauma.* 1st ed, Media, PA: Williams & Wilkins; 1996:423-431.
18. Yim APC. Minimizing chest wall trauma in video-assisted thoracic surgery. *J Thorac Cardiovasc Surg.* 1995;109:1255-1256.
19. Graham DD, McGahren ED, Tribble CG, Daniel TM, Rodgers BM. Use of video-assisted thoracic surgery in the treatment of chylothorax. *Ann Thorac Surg.* 1994;57:1507-1512.
20. Jimenez-Merchan R, Garcia-Diaz F, Arenas-Linares C, Giron-Arjona JC, Congregado-Loscertales M, Loscertales J. Comparative retrospective study of surgical treatment of spontaneous pneumothorax. *Surg Endosc.* 1997;11:919-922.
21. Pellegrini C, Wetter LA, Patti M. Thoracoscopic esophagomyotomy. Initial experience with a new approach for the treatment of achalasia. *Ann Surg.* 1992;216:291-293.
22. Bardini R, Segalin A, Ruol A, Percchia A. Videothoracoscopic enucleation of esophageal leiomyoma. *Ann Thorac Surg.* 1992;54:576-577.
23. Salo JA, Kiviluoto T, Heikkila LJ, Perhoniemi V, Lamminen A, Kivilaakso E. Enucleation of an intramural esophageal lipoma by videothoracoscopy. *Ann Chir Gynaecol.* 1993;82:66-69.
24. Salo JA, Kiviluoto T, Heikkila L, Nemlander A, Ikonen T, Kivilaakso E. Thoracoscopic fundoplication. *Ann Chir Gynaecol.* 1993;82:199-201.
25. Carrillo EH, Heniford BT, Dykes JR, McKenzie ED, Polk HC Jr, Richardson JD. Cardiac herniation producing tamponade: The critical role of early diagnosis. *J Trauma.* 1997;43:19-23.

Information for Authors

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal.* The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

Copyright assignment — In view of The Copyright Revision Act of 1976, effective January 1, 1978, transmittal letters to the editor must contain the following language and must be signed by all authors: "In consideration of *The Journal of the Kentucky Medical Association* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to *The Journal* in the event that such work is published by *The Journal.*"

References — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus.* Authors are responsible for reference accuracy.

Illustrations — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

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APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association
1998 Annual Meeting

Commonwealth Convention Center, Louisville, KY
September 21-23

1. Title of exhibit _____

2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____

3. Institution if other than exhibitor _____

4. Amount of backwall footage required _____

   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____

   (Table 2′ deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____

5. Will summary printed matter be available or obtainable for the interested physician? _____

6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
4965 US Hwy 42, Ste 2000
Louisville, KY 40222-6301

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 30, 1998.

- **COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.**
- **KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.**
- **Exhibit must be dismantled and removed by 8:00 PM, Wednesday, September 23, 1998.**
- **Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.**

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

Pulmonary Function Testing: Detection of Invalid Performance

Sandra Schuldheisz, MD; Barbara A. Phillips, MD, MSPH; David T. R. Berry, PhD

We surveyed physician members of the American Thoracic Society and their technicians regarding indicators of the validity of PFTs. Surveys were returned by 50 physicians and 52 technicians. Both groups felt that consistency of effort and the shape/slope of the curve were important indicators, with behavioral observations rated slightly lower. Approximately 38% of physicians and 19% of technicians felt that they detected 75% or fewer of individuals giving inadequate effort during PFTs. Twenty percent of physicians and 29% of technicians were using quantitative criteria other than those recommended by the 1979 "Snowbird" technical paper to determine acceptability of PFTs. Twenty-eight percent of physicians and 31% of technicians spontaneously indicated that patients pursuing compensation or disability claims for pulmonary disorders were most likely to give suboptimal effort. Empirical research into the impact and detection of suboptimal effort on PFTs is encouraged.

From the Pulmonary and Critical Care Division, Department of Medicine, College of Medicine (Drs Schuldheisz and Phillips); and the Department of Psychology (Dr Berry), University of Kentucky, Lexington, KY.

Recently, the Kentucky General Assembly dramatically revised the procedures for disability determination of pneumoconiosis in the Commonwealth.[1] A major change has been an increased emphasis on radiographic testing and pulmonary function testing in these disability determinations. These changes may prove to be problematic from at least two perspectives: ambiguities in interpretation of radiographic findings and the role of patient motivation in pulmonary function tests (PFTs).

Radiographic evaluation of individuals with coal-workers' pneumoconiosis (CWP) has inherent weaknesses. For example, radiographs of individuals who have never worked in coal mines may show the same patterns as those of exposed individuals.[2,3] Further, cigarette smoking alone may result in radiographic findings identical to those found in CWP.[4] Given the facts that cigarette smoking is highly prevalent in Kentucky, that false positive radiographic findings may occur in individuals without coal dust exposure, that CWP is the most common basis for pulmonary related disability claims in Kentucky, and that radiographic findings overlap considerably in CWP and other conditions, the stage may be set for inaccurate and costly determinations in disability evaluations.

Because the new statute dictates that disability claimants with radiographic findings compatible with CWP must then undergo PFTs to establish the functional impact of their abnormal findings, the validity of PFT results is an important issue.

Because individuals undergoing PFTs must exert reasonable and at times strenuous effort in order to achieve interpretable results, the issue of motivation of the test-taker may be of concern. Individuals involved in disability evaluations may harbor conflicting goals during their PFTs, wanting on the one hand to cooperate with the technician administering the test, but on the other hand desiring financial award for their perceived disability. To the extent that PFT depends on adequate effort by the patient, these conflicting motivations may in some cases pose a threat to the validity of test results.

The importance of adequate effort during PFTs is in fact highlighted by the 1979 "Snowbird Paper,"[5] still the accepted standard in the area. According to this document, the technician must observe "that the patient understood the instructions and performed with a smooth continuous exhalation, with apparent maximal effort, with a good start and without" a variety of potential confounds such as coughing or early termination which might invalidate the results. The standards outlined in the paper also emphasize the need to obtain consistent results from at least three acceptable curves, with two of the best three curves varying by not more than +/− 5% of reading or +/− 100 ml, whichever is greater.

Given the clearly defined need for adequate effort in obtaining valid PFT results, the expressed

Table 1. Physician Responses to PFT Survey

Vorioble		
Annuol Number Spirogroms	M (SD)	1216 (887)
Importonce of Consistency	M (SD)	5.46 (.93)
Importonce of Shape of Curve	M (SD)	5.46 (.86)
Importonce of Technicion Notes	M (SD)	5.00 (.95)
Percentoge of Inadequotely Motivated Patients Detected	1-25%	4%
	26-50%	4%
	51-75%	30%
	76-99%	58%
	100%	4%
Criterio for Determining Acceptable Consistency	±3%	4%
	±5%	80%
	±7%	8%
	±10%	2%
	NR	6%
Type of Potient Most Likely to Give Suboptimol Effort		
Compensotion/Disobility	28%	
Ill/Weok/Fotigued	14%	
Elderly	12%	
Poor Education/Illiterate	8%	
Depressed/Neurotic	8%	
Children	6%	
No Response	6%	
COPD	4%	
Poin	3%	
Other Response	11%	

Table 2. Technician Responses to PFT Survey

Vorioble		
Annuol Number Spirogroms	M (SD)	1593 (1799)
Importance of Consistency	M (SD)	5.48 (.75)
Importance of Shope of Curve	M (SD)	5.33 (.92)
Importance of Technicion Notes	M (SD)	4.83 (1.2)
Percentage of Inodequotely Motivoted Potients Detected	1-25%	4%
	26-50%	15%
	51-75%	60%
	76-99%	21%
	100%	4%
Criteria for Determining Acceptoble Consistency	±3%	15%
	±5%	71%
	±7%	2%
	±10%	4%
	NR	8%
Type of Potient Most Likely to Give Suboptimol Effort		
Compensotion/Disobility	31%	
Elderly	10%	
Children	10%	
Depressed/Neurotic	9%	
Poor Educotion/Illiterote	7%	
COPD	6%	
Angry	4%	
No Response	3%	
Other Response	19%	

concern in the literature regarding the impact of suboptimal effort in selected cases,[6-9] and the new importance of PFT results in Kentucky's pneumoconiosis disability determination guidelines, we undertook a survey to determine current clinical practice and thinking in this area.

Methods

We constructed a survey instrument requesting information on several aspects of PFTs from active pulmonologists and technicians across the country. The questionnaire is reproduced in Appendix A. This instrument was faxed to 200 randomly selected physicians listed in the American Thoracic Society membership directory. Physicians were requested to complete the instrument, to ask their PFT technicians working in laboratories with which they were associated to complete a second copy of the instrument, and to fax their results to us.

Results

We received responses from 50 physicians and 52 technicians, a return rate of approximately 25%. Tables 1 & 2 present results from the physician and technician respondents respectively on the importance of various factors in assessing the validity of PFT results. It can be seen that consistency of effort and the shape/slope of the curve were rated as highly important by both physicians and technicians in determining the validity of PFT results. Behavioral observations were also rated as important for this determination, although not quite as highly as the other two factors.

Regarding detection of inadequately motivated patients, relatively few technicians and physicians felt that they were able to detect all patients giving suboptimal effort. In fact, 38% of physicians and 19% of technicians felt they detected only three-quarters or fewer of patients giving suboptimal effort on PFTs. These results suggest some concern by front-line personnel regarding their ability to identify patients who are inadequately motivated during PFTs.

A second finding of interest was the variability of quantitative criteria used to determine acceptability of PFT results. Twenty percent of physicians and 29% of technicians indicated that they used a criterion other than the one expressed in the 1979 Snowbird technical paper to determine acceptability of PFT results from a quantitative standpoint.

A third important finding of interest was that

28% of physicians and 31% of technicians spontaneously indicated that the type of patient most likely to give suboptimal effort was one who was involved in disability or compensation determination.

Conclusions

This preliminary national survey of physicians and technicians working with PFTs indicated that persons involved in compensation seeking are thought to be the most likely to give inadequate effort on testing, and that only a minority of medical personnel believed that they detected all such individuals. Given the new importance of PFT results in Kentucky's pneumoconiosis disability procedures, it appears that empirical research into this issue is badly needed. One other relevant issue is the fact that quantitative criteria used to determine the acceptability of PFT results vary from recommended standards in a significant minority of PFT laboratories. This factor may also influence the validity of results from PFTs used in disability determinations.

References

1. House Bill 1 (HB-1), General Assembly, Commonwealth of Kentucky, December 12, 1996.
2. Meyer JD, Islam SS, Ducatman AM, McCunney RJ. Prevalence of small lung opacities in populations exposed to dust. *Chest.* 1997;11:404-410.
3. Epstern DM, Miller WT, Bresmitz EA, Leuke MS, Gefter W. Application of ILO classification to a population without industrial exposure: Findings to be differentiated from pneumoconiosis. *AJR* 1984;142:53-58.
4. Blanc PD, Gamsu G. The effect of cigarette smoking on the detection of small radiographic opacities in inorganic dust diseases. *J Thorac Imag.* 1988;3:51-56.
5. ATS Statement — Snowbird workshop on standardization of spirometry. *Am Rev Respir Dis.* 1979;119:831-838.
6. Suratt PM, Hooe DM, Owens DA, Anne A. Effect of maximal versus submaximal effort on spirometric values. *Respiration.* 1981;42:233-236.
7. Park SS. Effect of effort versus volume on forced expiratory flow measurement. *Am Rev Respir Dis.* 1988;138:1002-1005.
8. Krowka MJ, Enright PL, Rodarte JR, Hyatt RE. Effect of effort on measurement of forced expiratory volume in one second. *Am Rev Respir Dis.* 1987;136:829-833.
9. Crapo RO. Pulmonary function testing. *N Engl J Med.* 1994;331:25-30.

Appendix A

SURVEY ON EFFORT, MOTIVATION AND PFTS
PHYSICIAN FORM

Name:_____ Position:_____

Lab name or location: _____

Phone #: _____ FAX #:_____

Estimated annual number of spirograms/flow volume loops: _____

Please rate the following for importance in determining patient effort/motivation during spirometry/flow volume loops using the scale below:

	Useless 1	2	3	4	5	Essential 6
Consistency of effort _____						
Shape/slope of curve _____						
Tech notes on patient behavior _____						

Please list any other indicators of effort you have found useful:

Of patients who are NOT giving optimal effort, what percentage do you think you DETECT (please circle one)?

0% 1-25% 26-50% 51-75% 76-99% 100%

What criteria do you use to determine acceptable consistency of effort (please circle one)?

within 3% of best within 5% of best within 7% of best other_____

What techniques does your lab use to obtain the patient's best effort?

_____

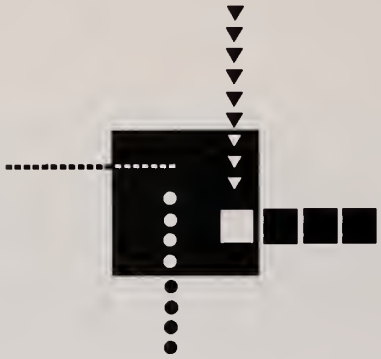
In your experience, what types of patients, if any, are less likely to give optimal effort during pulmonary function testing? _____

_____

Thank you for your help. Please FAX to Dr Phillips at (606) 323-1020.

Please check here if you would like a summary of our findings faxed to your number given above ❑.

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- **Managing physician organizations**
- **Negotiating and resolving conflicts**
- **Helping and handling the disruptive physician**
- **Emerging information technology**
- **Capitation**
- **Stark II recommendations**
- **Antitrust**
- **Organized medical staff challenges in the future**
- **Effectively communicating in business practice**
- **PSOs and Medicare risk contracting**
- **Unionizing**
- **E/M Documentation Guidelines**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit ** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America

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KMA Legislative Report

KENTUCKY MEDICAL ASSOCIATION

REPORT ON THE

1998 KENTUCKY GENERAL ASSEMBLY

WALLY O. MONTGOMERY, MD, CHAIR

The 1998 Kentucky General Assembly adjourned on April 15. During the 1998 Session, 1709 bills and resolutions were introduced, and KMA followed and closely monitored 237 proposals. While "media wise" social issues were dominant, there were several landmark budgetary issues, particularly in higher and secondary education funding and tax base restructuring, which ultimately may become the true legacy of the 1998 Session. The economic upswing and resultant stabilization of the economy was good news for Kentucky as it was for the nation. On behalf of the Association, we are deeply appreciative of members of the General Assembly and the Administration for their support on many issues of concern to medicine. We thank those physicians and spouses who contacted their Legislators on important legislation relating to patient care and the profession. In addition we want to recognize the KMA Alliance for their assistance by operating the Phone Bank in 1998. Everyone on the legislative team including KMA leadership, lobbyists, and staff did an outstanding job. We are profoundly indebted to Representative Bob M. DeWeese, MD, for his statesmanship and political astuteness in guiding several patient oriented legislative proposals through the 1998 Kentucky General Assembly.

The KMA House of Delegates established the following legislative priorities for the 1998 Session:

- Patient Protection/Provider Fairness
- Professional Liability Reform
- Health and Safety

For readership purposes, this report is categorized into 12 Sections:

- Patient Protection/Provider Fairness
- Professional Liability/Plaintiff Lawyers
- Health and Safety
- Non Physician Practitioners
- Alternative/Complementary Health
- Medicaid
- Kentucky Child Health Insurance Program
- Abortion/Marriage
- Certificate of Need
- Other Medical Issues
- Health Insurance
- Non Medical Issues

PATIENT PROTECTION

KMA's primary focus during the 1998 Session was to enact Patient Protection and Provider Fairness legislation in accordance with House of Delegates directives. KMA elected to include Patient Protection/Provider Fairness legislation within HB 315, the DeWeese-Damron proposal to reform health insurance, rather than presenting the proposal as a separate and distinct bill. The legislative strategy to include Patient Protection/Provider Fairness in HB 315 was made in consultation with General Assembly leadership, sponsors of the legislation, KMA leadership and lobbyists. Based on reports from other states and AMA's experience with the 1997 Congress, this turned out to be the correct decision. In 1997 Chambers of Commerce, business and the managed care industry coalesced to defeat these proposals in Congress and several states.

HB 315 included the following Patient Protection/Provider fairness components: **(Adopted)**

Patient information from insurers:
Requires all insurers to state, in writing, the conditions, terms and information, such as appeals mechanisms, prior authorization procedures, restrictions on access to providers, and other review mechanisms imposed by the insurer.

Financial disclosure to patients:
Managed care plans must include lists of physicians, by county, specialty and hospital affiliation, and disclose any financial incentives from the managed care plan and other appropriate consumer information.

Adequate staffing:
All managed care plans must have sufficient numbers of primary care, specialist providers, and facility access for their enrollees. Telephone access to the plan must be available, and reasonable standards must be established for waiting times to obtain appointments.

Choice of primary care provider:
Adequate choices of primary care must be available. Patients must be allowed to choose their primary care provider from the plan list.

Use of Specialists as primary care provider:
Plans must permit patients to use specialists as a primary provider when medical conditions warrant.

Prudent layperson definition of emergency:
Emergency care must be available without prior authorization, and the definition of "emergency" must be defined in terms a "prudent layperson" understands.

Prohibit gag clauses:
Plans are prohibited from limiting providers disclosure of medical conditions or treatment options to patients.

Once prior approval is granted claim can only be rejected in cases of fraud:
When prior approval has been obtained, coverage shall not be retrospectively denied unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information by either the patient or the provider.

Requires managed care to comply with "Do not substitute" provision:
When a physician determines that generic substitution of a pharmaceutical product is medically inappropriate, the pharmacist shall prescribe the product the physician determines medically appropriate with the indication "do not substitute." No substitution shall be made without the physician's approval.

PROVIDER FAIRNESS

De-selection/Termination of provider
Each plan must have a policy governing de-selection or termination of a provider from a network. If requested by the provider, the network must provide a reason for termination and hold a hearing within 30 days.

Medical Director
The Medical Director must be licensed in the state in which he or she is employed, and is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan. Decisions to deny, reduce, or terminate a health care benefit or to deny payment for a health service, because that service is not medically necessary, shall be made by a physician.

Prohibit "most favored nation clauses"
Insurance contracts cannot contain a most favored nation provision unless the Commissioner determines the market share of the insurer is nominal.

Prohibit discriminatory payments to providers
Providers under the guaranteed acceptance program (GAP) shall be reimbursed at rates that are no less favorable than the rates paid to comparable providers for services delivered to enrollees who do not have a high-cost condition.

Point of service option
Every plan must provide "point of service" or out-of-network benefits to every contract holder that allows a covered person to receive covered services from out-of-network providers without having to obtain a referral.

Any willing provider
Health insurers cannot discriminate against any provider who is located in the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health insurer, including Medicaid and Medicaid partnerships.

Insurer accountability
Insurer accountability for limiting coverage for any treatment, procedure, drug, or device is required. When coverage is denied, a letter provided in a timely manner must identify the person making the denial; give the reason for the denial; and, outline alternative services, treatment, or procedures.

PROFESSIONAL LIABILITY REFORM/PLAINTIFF LAWYERS

KMA's other primary legislative goal was tort reform. Due to Patient Protection/Provider Fairness legislation, we spent an inordinate amount of time on the "tort reform" defensive, opposing bills disguised as "social legislation," which in reality were efforts by plaintiff lawyers to expand rights of actions.

Wrongful Death/Fetal Personhood

HB 293 Currently, there is no claim for "loss of consortium" where an "unborn child in utero without regard to state of gestation" is involved. HB 293 would have provided for damages to be recovered for the death and "for grief and loss of companionship" from the person who caused it. While the bill exempted physicians and mothers participating in the abortion, it provided no protection for physicians performing OB care, amniocentesis, or prescribing medications.

Waiver of Sovereign Immunity

HB 667 granted a waiver of sovereign immunity if the state purchased liability insurance or maintained self-insurance. HB 667 would have placed at risk physicians employed by the state or its entities, and physicians serving on state boards and commissions.

Cause of Action Against a Third Party Defendant

HB 796 would have eliminated the statue of limitations regarding claims against third party defendants in malpractice and other personal injury actions.

Definition of a Person

SB 249 proposed amending statutes to include all human beings from fertilization to death in the definition of a person.

Parental Consent Prior to Counseling/Treating Minors

SB 294 mandated, "by statute," that physicians obtain consent from parents/guardians before diagnosing, treating, or counseling minors (0-18).

HMO Liability for Patient Injury

SB 322 required HMOs making medical treatment decisions to be liable for damages for harm to an enrollee.

Tort Reform

SB 411 proposed to limit damages, attorney solicitation of clients, regulate attorney fees and punitive awards, provide for structured settlements, and limit non-economic loss. SB 411 was an effort to reintroduce serious discussion of broad sweeping tort reform and may be a precursor to tort reform in 2000.

HEALTH & SAFETY

Motorcycle Helmet Law

HB 106 permits individuals over 21, with a prescribed training course, to operate motorcycles without helmets. **(Adopted)**

Tobacco

SB 146 transferred jurisdiction of minors who illegally purchase tobacco products from the Department of Agriculture to the Juvenile Session of District Court. HFA 3 prohibited purchase of tobacco products by persons under age 18. HFA 4 prohibited persons from providing persons under 18 with tobacco products. **SB 146 was adopted—but HFA 3 & 4 were defeated.**

SB 307 prohibits "individual" sales of cigarettes. (**Adopted**)

HB 381 Permitted local governments to enact more stringent penalties to restrict youth access to tobacco. Amended to a "Task Force on Teens and Tobacco." **Passed the House but died in the Senate.**

HB 561 prohibited possession of tobacco by persons under 18.

HB 917 Imposed 25 cent tax per pack on cigarettes for agricultural assistance and diversification.

Driving Under the Influence (DUI)

HB 327 reduced the allowable BAC from 0.10 to 0.08.

HB 455 Individuals blowing above 0.18 BAC become Class D felons. **(Adopted)**

Water/Boat Safety

HB 1 establishes age limits for operators to enhance water safety. **(Adopted)**

TB Testing

HB 131 eliminated the requirement for TB testing. **(Adopted)**

Hepatitis B

HB 156 Mandates Hepatitis B test for pregnant women. **(Adopted)**

Closing Restaurants When Imminent Danger to the Public Exists

SB 68 permits health departments to close restaurants without a hearing in the presence of imminent danger to the public. **(Adopted)**

Pick-up Truck/Riders

HB 192 prohibited minors from riding in open vehicles on public highways.

Bicycle Helmets

HB 254 required minors under age 12 to wear helmets when riding bicycles.

HB 189 requires study of promising health care services to school children by school personnel not licensed or certified to perform health care services. **(Adopted)**

NON PHYSICIAN PRACTITIONERS

Nurses

HB 187 requires nurses and other licensed, registered, certified, or otherwise regulated employees in a hospital to wear badges or insignia, provided it does not violate sterile procedures. **(Adopted)**

HB 190 Permits ARNPs to sign statements that a child's medical condition prevents or renders inadvisable attendance at school. **(Adopted)**

HB 285 Permits nurses who have successfully completed required training to make determinations of death. **(Adopted)**

HB 603 requires that nursing facilities provide for a criminal record check of nurses as a condition of employment. **(Adopted)**

HB 637 created a "Clinical Nurse Specialist" permitted to prescribe under ARNP guidelines.

Optometrists

SB 356 mandated direct access to managed care patients by optometrists. **(Withdrawn)**

Athletic Trainers

SB 285 expanded the practice of athletic trainers by permitting them to work with "physicians," rather than "team physicians" and broadly defined the term "athlete."

Clinical Exercise Physiologist

HB 403 licensed Clinical Exercise Physiologists.

Physician Assistants

SB 28 permits PAs in a collaborative agreement with a physician to prescribe non-legend drugs. **(Adopted)**

Pharmacists

HB 649 authorizes pharmacists to assist patients dealing with tests in inventory and which can be sold without a prescription or order. Pharmacists with collaborative agreements and as authorized by the collaborating physician, may perform additional tests and perform appropriate follow up treatment as permitted under the terms of the agreement with the physician. **(Adopted)**

Marriage and Family Counselors

SB 380 licenses Marriage and Family Counselors. **(Adopted)**

Pastoral Counselors

HB 608 Requires "fee based" Pastoral Counselors to be certified. **(Adopted)**

Paramedics

HB 285 permits Paramedics who have completed a required training course to make determinations of death. **(Adopted)**

ALTERNATIVE/COMPLEMENTARY HEALTH

Naturopathy

HB 158 licensed Naturopaths, granted prescriptive privileges, allowed them to perform minor surgery, remove foreign objects, perform acupuncture, obstetrical delivery, manipulative therapy, and other medical procedures and services.

Acupuncture

HB 160 established the Board of Acupuncture/Oriental medicine. HB 160 authorized "defined" practitioners to use all diagnostic and treatment techniques of acupuncture, oriental, traditional, and modern medical techniques for the prevention or correction of a malady, illness, injury , pain, or other conditions. **A Committee substitute deleted all contents of 3 legislative proposals (HB 158/160/243) and replaced them with a directive to study benefits and effects of complementary and alternative medicine. The Commission will be composed of various representatives including the Board of Medical Licensure, KMA, three medical schools and others. (Adopted)**

Nonconventional Medical Treatment

HB 243/SB 375

proposed creation of "Complementary or Nonconventional medical treatment" practitioners under the Board of Medical Licensure. The legislation redefined dishonorable and unethical conduct and character and limited the Board of Medical Licensure's ability to discipline alternative practitioners. The Board would have been prohibited from construing as an act of unprofessional conduct a physician's use of any conventional or nonconventional medical care with a reasonable expectation of efficacy in the treatment of human conditions, ailments, diseases, injuries, or infirmities.

MEDICAID

Regional Medicaid Partnerships

SB 305 delayed expansion of the Medicaid regional partnerships outside Regions 3 and 5 until 2000 and prohibited placing mental patients under managed care.

HB 178 exempted mentally retarded persons from Medicaid managed care.

HB 213 exempted developmentally disabled from Medicaid managed care.

HB 785 establishes a Medicaid Managed Care Oversight Advisory Committee to provide oversight on the implementation of Medicaid managed care including access, utilization, quality, and cost containment. **(Adopted)**

Mandatory Participation in Medicaid

HB 124 mandated participation in Medicaid, tied to medical license.

Abolish Medicaid Pre-authorization for Drugs

SB 351 directs that no prior authorization be required for reimbursement of claims involving drugs covered by Medicaid for a period of 12 months, during the time which the Drug Management Review Advisory Board may review the product. Safety and high cost measures are included which permit the Medicaid Department to withhold approval if necessary or appropriate. **(Adopted)**

HB 118 required the Administration to request a federal waiver to cover autism and pervasive developmental disorder under Medicaid.

Fraud and Abuse

HB 227 required physicians participating in the Medicaid Managed Care program to be potentially liable for a felony for "refusing to refer . . . a patient . . . when medically necessary." Such standards were so nebulous that in any instance where an inappropriate result occurred, a physician could be charged with a Class D felony. In other words, if an inappropriate result occurred . . . something medically necessary, ie, referral, did not occur; therefore the physician is guilty. HB 541 was subsequently introduced to correct deficiencies of HB 227, but never received a hearing.

Medicaid Coverage for Children 14-18 at 100% FPL (KCHIP)

SB 128 includes a provision calling for the Commonwealth to include all children from 14-18 under the Medicaid program. **(Adopted)**

KENTUCKY CHILD HEALTH INSURANCE PROGRAM (KCHIP)

Eligibility/Funding/Administration

SB 128 in accordance with the 1997 Federal Budget, authorizes KCHIP and funds the state program with matching money for a period of 10 years. Approximately 90,000 of 125,000 uninsured children will be eligible for this free or low cost program. Kentucky's 1998-99 budget funds KCHIP with $13 million which in turn will be matched by a $50 million federal subsidy. SB 128 directs KCHIP to be administered by the Department of Medicaid. Health coverage will be available for children under age 18 up to 200% of the FPL. Administration costs are limited to 10%, and a seven member advisory council will oversee the program. Health Departments are permitted to bid for services, and Managed Care Partnerships will be eligible to participate in the program. **(Adopted)**

KCHIP Schedule of Benefits:

Medicaid reimbursement schedules will be used under the program, except for those regions where Partnerships manage the program. Patients may obtain dental and vision care directly. Benefits will match either Blue Cross/Blue Shield federal employee program, state employees' mid-range plan, or a program promoted by the state's largest HMO. **(Adopted)**

ABORTION/MARRIAGE

Abortion

24 hour waiting period/info distribution

HB 85 requires women to wait 24 hours before obtaining an abortion after reviewing various pictures, drawings and other information. **(Adopted) (Vetoed) (Overridden)**

Partial Birth Abortion

SB 124 criminalizes the "partial birth abortion" procedure. **(Adopted)**

Licensing Standards for Abortion Facilities

SB 217 requires physician offices where abortions are performed to be licensed. **(Adopted)**

Marriage

HB 11 prohibited same sex marriage.

HB 13 renders same sex marriages occurring in foreign jurisdictions unenforceable in Kentucky. **(Adopted)**

HB 37 prohibits marriage of persons under 16. **(Adopted)**

HB 702 required statement on marriage license that domestic violence is illegal.

CERTIFICATE OF NEED

State Health Plan

SB 306 codified the State Health Plan which placed restrictions on physicians seeking exemptions from SHP via the Administrative Regulatory Review process.

Extend CON

SB 374 provides a six month extension for projects. **(Adopted)**

CON for Physician Offices

HB 922 Required physician office/clinic providing some surgical procedures to be licensed as an ambulatory surgery center.

OTHER MEDICAL ISSUES

Controlled Substance Abuse

HB 115 authorizes the development of a computer network of pharmacies, and a centralized network established through CHR. Eventually, pharmacists, physicians and other providers, by accessing the computer network, will be able to determine if a patient is a "doctor shopper" or an abuser of the system. Following a "date certain" prescriptions for controlled substances may only be written on secure "copy and erasure" proof paper. **(Adopted)**

Charitable Health Care Provider

HB 128 provides for charitable health care providers to render care within their scope of licensure. License granted under reciprocal agreements to an individual from another state/country is evidence of a Kentucky license. Budgets $20,000 for liability insurance that the state will provide. **(Adopted)**

Emergency Medical Services for Children (EMSC)

HB 249 establishes the EMSC to engage in data collection relating to child emergency medical services and trauma care. The Cabinet for Health Services will establish the Emergency Medical Services for Children Program. **(Adopted)**

Warranties for New Assistive Devices

HB 410 requires manufacturers of assistive devices to expressly warrant the device against any condition, defect, or malfunction which substantially impairs the use, value, or safety of the device for one year. Requires that only the manufacturer invoice price be refunded for hearing aids. **(Adopted)**

Breast Cancer Advisory Committee

HB 476 adds a radiologist fellowship trained in breast diagnostics to membership on the Breast Cancer Advisory Committee. **(Adopted)**

Living Will Expansion

HB 529 permits a person to use a living will to give all or any part of the body upon death for any purpose specified under KRS 311. 185. **(Adopted)**

Brain Injury Trust Fund

HB299 establishes the Brain Injury Trust Fund, funded by imposing fines on vehicle moving violations and DUI. **(Adopted)**

Osteopathy

SB 202 provides tuition to eligible Osteopathy Medical School students intending to practice in the Commonwealth. **(Adopted)**

Birth Surveillance Registry

SB 336 directs licensed free-standing birthing centers/general acute care hospitals give access to medical records to the Birth Surveillance Registry. **(Adopted)**

Confidentiality of Peer Review

SB 268/HB 711

includes in the definition those proceedings, records, opinions, conclusions, and recommendations made during a designated professional review function which are to be kept confidential and privileged, medical malpractice proceedings, actions arising out of review of credentials or of retrospective review, and actions by an applicant or grantee for staff privileges.

HEALTH INSURANCE

Autism

SB 63 requires health benefit plans to provide limited health coverage for autism for therapeutic respite and rehabilitative care. **(Adopted)**

Emergency Care

SB 227 requires health benefit plans to cover and reimburse expenses for emergency care without prior authorization in certain situations. **(Adopted)**

Cochlear Implants

SB 135 requires health benefit plans to cover cochlear implants. **(Adopted)**

Diabetes

HB 380 requires health benefit plans to cover diabetes. **(Adopted)**

Hearing Screening

HB 456 requires infant hearing screening before being discharged from hospitals and health benefit plans to provide insurance coverage. **(Adopted)**

Unfair Trade Practices/Provider Discounts

HB 457 establishes that it is an unfair trade practice if an insurer fails to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health care provider from the insurer. **(Adopted)**

Cancer Drugs/Treatment

HB 618 requires all health benefit plans not to exclude coverage of cancer drugs when used for an indication other than one on its label if the drug is recognized for that indication in the official compendium or medical literature. Requires professional journal publications to meet specific criteria and include documentation regarding drug safety and effectiveness. Requires reimbursement if the drug has been prescribed for cancer patients and recognized as safe for cancer treatment. A panel of medical experts, nominated by the KMA, will be appointed by the Commissioner. **(Adopted)**

Women's Health Insurance

HB 864 requires health benefit plans to offer coverage for all stages of breast reconstruction surgery following a mastectomy that resulted from breast cancer if the insurer covers mastectomies; diagnosis and treatment of endometriosis and endometritis if the insurer covers hysterectomies; bone density testing for women age 35 and older, when indicated by the health provider. **(Adopted)**

NON MEDICAL ISSUES

Lethal Injection/Capital Punishment

HB 27 replaces electrocution as a form of capital punishment with lethal injections. Physicians are prohibited from participating in an execution except to certify death, and only after the condemned has been declared dead by another individual. **(Adopted)**

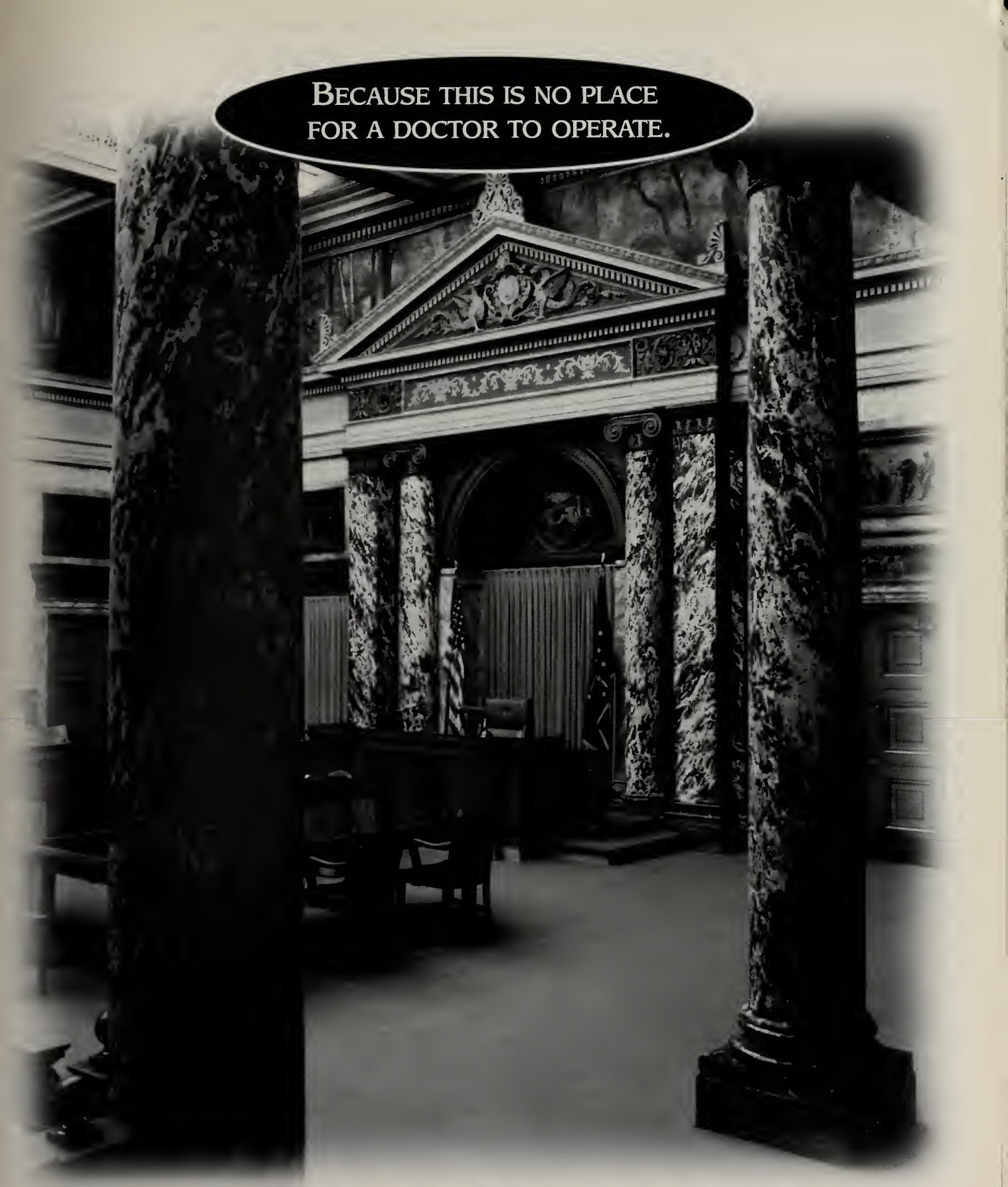
Annual Sessions

HB 246 a proposed constitutional amendment, permits the General Assembly to convene for 25 days in odd number years. **(Adopted)**

Administrative Regulations

HB 287 allows the public to more effectively participate in the regulatory process. HB 287 requires notice to interested parties, standards for deferral of regulations, more equitable consideration of oral and written comments, and additional public hearings if necessary. **(Adopted)**


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AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222-6301

Deadline for receiving nominations is July 15.

Which Medical School Applicants Will Become Generalists or Rural-Based Physicians?

Stephen W. Looney, PhD; Richard D. Blondell, MD; Janice R. Gagel, MSN; Margaret W. Pentecost, MAT

The hypotheses that data, available at the time when a medical school admission decision is made, can be used to predict generalist specialty choice and rural practice location were tested. Applicant data, available to admissions committee members at the University of Louisville in 1986 and 1987 about the classes of 1990 and 1991 respectively, were correlated with specialty choice and practice location in a retrospective cohort study. Data collected from 1994 to 1996 about the 1990 and 1991 graduates were used to develop a mathematical model to predict specialty choice and practice location using stepwise logistic regression. These models were more accurate in predicting which applicants would not select a generalist career (negative predictive value = 80.7%) than those who would (positive predictive value = 42.7%) and in predicting those who would not practice in a rural location (negative predictive value = 91.9%) than those who would (positive predictive value = 37.8%). We conclude that applicant data, available at the time admission decisions are made, are of limited value for identifying those who will eventually become generalist physicians or practice in a rural area. However, the data are useful for identifying those who will not.

Kentucky has an adequate number of physicians for the total population, but still experiences shortages of generalist and rural-based physicians. Of the 120 counties in the Commonwealth, all of 49 counties and portions of another 27 are designated as Health Professional Shortage Areas for Primary Care.[1] Most of these counties are in rural areas. This problem is likely to continue into the future. From 1991 to 1993, the number of primary care physicians in Kentucky increased by only 14 (from 1269 to 1283) while the number of all other physicians increased by 1715 (from 5641 to 7356).[1] A similar situation exists across the nation which prompted the Association of American Medical Colleges (AAMC) to suggest that medical schools "adjust their admission criteria to increase the matriculation of qualified applicants who evince genuine interest in a generalist career."[2]

The selection of a career specialty is a complex and poorly understood process. Of the many factors that appear to influence specialty choice, only those features that are known to admissions committee members can be used to help make decisions about whether or not to admit a given individual to medical school. Bland and her colleagues analyzed 307 references about specialty choice published between 1987 and 1993.[3,4] This analysis identified only a few characteristics, present at the time of admission to medical school, that appear to be associated with a generalist career choice: being female, older, and married; having a broad undergraduate background; and having non-physician parents. Blue and her colleagues at the University of Kentucky found that future generalists often make their career decision before entering medical school, but note that student-expressed interest in a generalist career is not used as an admission criterion at their institution.[5]

It has been known for decades that medical students from rural areas are more likely to eventually practice in rural areas than are students from urban areas and vice versa.[6] Recent studies continue to confirm this.[7,8] Elam and her colleagues found that medical school graduates of the University of Kentucky tended to return to their in-state district of origin to practice and that men were more likely than women to locate their practice in a rural area.[9]

Is it possible for admissions committee members in Kentucky to identify which applicants

From the University of Louisville Department of Family and Community Medicine. Drs Looney and Blondell are Professors; Ms Gagel is a Medical Student; and Ms Pentecost is a Curriculum Coordinator.

This study was supported, in part, by the University of Louisville School of Medicine Research Committee. A report of the initial data collection was presented at the 1995 Resident/Student Research Forum of the American Academy of Family Physicians on July 29, 1995, in Kansas City, MO.

who are not only qualified to become successful medical students and competent physicians, but are also likely to become generalist physicians and/or practice in rural areas? Committee members must consider a large amount of applicant data before rendering a decision about who is admitted to medical school: demographics (age, gender, race, marital status, hometowns, etc); educational background (college major, grades, aptitude test scores, etc); and interview scores concerning personality, motivation, career goals, and so forth. At the University of Louisville, admissions committee members pay particular attention to applicants who participated in the Professional Education Preparation Program (PEPP), a statewide program designed to increase the likelihood that qualified rural students will apply to and be accepted by the state's health profession schools.

We hypothesize that there are factors, known at the time individuals apply to the University of Louisville School of Medicine, which are predictive of specialty choice and practice location. Furthermore, we hypothesize that mathematical models could be developed that can be used to estimate the probability at the time of admission that a given individual will choose a generalist career specialty or rural practice location.

Methods

Individuals who graduated in 1990 and 1991 from the University of Louisville School of Medicine were studied. These classes were selected because they were the most recent group to have chosen a career specialty, completed residency training and selected a practice location at the time of the initial data collection during the summer of 1994. Information that could not be obtained during the summer of 1994 was added to the database as it became available during the two years that followed.

Information available to the admissions committee when the subjects applied to medical school in 1986 and 1987 was obtained from the original application materials and included: demographic information (age, race, gender, marital status, number of children, parental occupation); hometown (rural, urban, PEPP county, other); whether or not the American Medical College Application Service (AMCAS) designated the subject as "rural"; participation in the PEPP; type (private, public) and location (in-state, out-of-state) of the subject's undergraduate school; undergraduate major (science, health care [eg, nursing, pharmacy], non-science); undergraduate Grade Point Average (GPA) in all courses and the GPA in science courses; graduate GPA, if applicable; scores for the sections of the version of the Medical College Aptitude Test (MCAT) in use in 1986 and 1987 (reading, biology, chemistry, physics, quantitative, and science problems); a score for the recommendation of the pre-medical (pre-med) college faculty; scores from the medical school interview; and whether or not this was the individual's second application to medical school. These data fields were selected based on reviews of the published studies on this subject.[2,3,6]

The undergraduate GPA and the GPA in science courses were obtained from the AMCAS summary form. The graduate GPA was calculated from the subject's course transcripts by officials in the admission office who also assigned a value (based on a 10-point Likert scale) to the pre-medical college recommendation. The subject's community at the time of high school graduation was used to determine the "hometown" and was considered to be "rural" if it had a population of less than 25,000 and was not located in a Bureau of the Census Metropolitan Statistical Area (MSA), and "urban" if within an MSA. Hometowns not satisfying the definition of rural or urban were classified as "other." Applicant interview scores rating various personality characteristics (scales I, II, III, IV, and overall) were based on a 6-point Likert scale.

These admissions data were correlated with the collected outcome data: academic difficulty (ie, course failures or repetition, failure on either part I or II of the National Board examination, and failure to complete medical school on schedule); specialty choice; and practice location. An attempt was made to contact all of the medical school graduates by telephone to confirm career specialty choice and practice location. Generalists were considered to be those practicing family practice, general internal medicine, general pediatrics, or medicine/pediatrics. The same definitions used for "rural," "urban," and "other" hometowns were also used to categorize practice location.

The Cochran-Mantel-Haenszel[10] method was used to test the statistical significance of and find a 95% confidence interval for the likelihood — referred to as "relative risk" in the terminology of statistics — of eventually choosing a generalist specialty or practicing in a rural area for each of the applicants' categorical characteristics (age, gender, marital status, etc) which were known at the time of application. The unequal variance

t-test[11] was used to compare the continuous characteristics (MCAT scores, GPA, interview ratings, etc) of those medical school graduates who chose a generalist specialty or a rural practice location with those who did not. All statistical tests were two-tailed. The Statistical Analysis System (SAS Institute, Inc, Cary, North Carolina, 1989) was used to perform all the calculations of this study.

Stepwise logistic regression[12] was used to select the combination of variables which best predicted generalist specialty choice and rural practice location. The "goodness-of-fit" of the resulting logistic models was assessed using the "score test."[12] The sensitivity, specificity, and predictive value of the prediction rules were estimated using a "jackknife" procedure in order to reduce the bias that results from classifying the same data used to construct the prediction rules.[13]

Results

Of the 234 graduates (120 from 1990 and 114 from 1991), 20 were lost to follow-up, leaving 214 subjects for analysis. There were 64 graduates (30%) who were practicing generalists, and 150 (70%) were either in a non-generalist practice or in the process of completing a non-generalist residency or fellowship. Of these same 214 subjects, 24 (11%) were practicing in a rural location, 113 (53%) were practicing in a non-rural location, and 77 (36%) were either still in postgraduate training (N = 66) or had not yet established a definite practice location (N = 11). Of the 214 subjects, only those for whom the data sets were complete were used to develop the prediction models, 210 for the generalist model and 206 for the rural practice model.

Table 1 summarizes the analyses of the characteristics significantly associated with the selection of a generalist specialty by the 214 subjects. Age, gender, race, marital status, hometown, and the GPAs did not correlate with a generalist specialty choice. Although those who selected a generalist specialty had lower mean scores for four of the six sections of the MCAT, they were no more likely to experience academic difficulty than the others.

Table 2 summarizes the analyses of the characteristics significantly associated with the selection of a rural practice location by the 214 subjects. Practice location did not correlate with age, gender, race, marital status, type or location of the undergraduate college, nor the GPAs. Those who selected a rural practice location were no more likely to experience academic difficulty than those who did not.

Table 1. Predictors of Generalist Specialty Choice

Predictor[1]	P-Value	Relative Risk	95% Confidence Interval
MCAT[2]: Science Problems (−)	0.008	N/A[3]	N/A
MCAT: Physics (−)	0.009	N/A	N/A
MCAT: Quantitative (−)	0.016	N/A	N/A
MCAT: Chemistry (−)	0.036	N/A	N/A
Private, out-of-state undergraduate education (−)	0.046	0.50	0.25-0.99
Undergraduate healthcare major (+)	0.048	2.57	1.01-6.56

[1]A plus sign (+) indicates a direct relationship with generalist specialty choice, and a negative sign (−) indicates an inverse relationship.
[2]Medical College Aptitude Test.
[3]Not Applicable for continuous characteristics.

Table 2. Predictors of Rural Practice Location

Predictor[1]	P-Value	Relative Risk	95% Confidence Interval
Urban hometown In Kentucky (−)	<0.001	0.24	0.11 to 0.52
Rural AMCAS[2] (+)	0.001	3.28	1.65 to 6.53
In-state rural hometown (+)	0.010	2.54	1.25 to 5.14
Undergraduate health care major (+)	0.025	4.03	1.19 to 13.62
Hometown in PEPP[3] county (+)	0.027	2.41	1.11 to 5.24
Out-of-state urban hometown (+)	0.034	3.10	1.09 to 8.80
Father, other health care professian (+)[4]	0.037	2.51	1.06 to 5.97
Interview rating: overall (+)	0.049	N/A[5]	N/A

[1]A plus sign (+) indicates a positive association with rural location, and a negative sign (−) indicates negative association.
[2]American Medical College Application Service.
[3]Professional Education Preparation Program.
[4]Health care profession other than physician.
[5]Not Applicable for continuous characteristics.

The predictors that were retained in the stepwise logistic regression analysis for the model to predict generalist specialty choice are listed in order of importance. A plus sign (+) indicates a positive association, and a negative sign (−) indicates a negative association. They were: quantitative MCAT score (−); reading MCAT score (+); graduate of a public out-of-state undergraduate school (+); graduate of a public undergraduate school in Kentucky (+); biology MCAT score (−); undergraduate health care degree (+); second application (−). For rural practice location, the following predictors were retained: instate urban hometown (−); quantitative MCAT score (+); non-rural, non-urban in-state hometown (−), and pre-

med score (−). The "score test" indicates an adequate fit of both the generalist specialty and rural location models to the data ($p = 0.001$ and $p < 0.001$ respectively).

The classification results for the logistic regression prediction models for generalist specialty selection and rural practice location are summarized in Table 3. The generalist specialty prediction rule accurately classifies the majority (63.3%) of the 210 graduates for whom a career specialty was known and for whom a complete data set was obtained. The rural practice prediction rule also accurately classifies a majority (73.3%) of the 131 graduates available for analysis (61% of the total), the remainder either were still in training or had not yet selected a practice location.

Table 3. Classification Accuracy of Predictive Models Based on Logistic Regression

Characteristic	Generalist Practice Choice	Rural Location
Accuracy	63.3% (133/210 correct)	73.3% (96/131 correct)
Sensitivity	65.1% (41/63 correct)	70.8% (17/24 correct)
Specificity	62.6% (92/147 correct)	73.8% (79/107 correct)
Predictive Value Positive	42.7% (41/96 correct)	37.8% (17/45 correct)
Predictive Value Negative	80.7% (92/114 correct)	91.9% (79/86 correct)

Conclusions

We conclude that certain applicant characteristics are predictive of the selection of a generalist specialty and rural practice location, but we were not always able to reproduce the findings of others. For example, gender, age, and marital status have been identified by others as significant, but did not correlate with a generalist specialty choice in our study population. We did appear to confirm the affinity model of practice location: graduates who were from a rural hometown were more likely to return to a rural area to practice than were graduates who were from an urban hometown in Kentucky. However, we found that graduates who were from an out-of-state urban hometown were more likely to select a rural practice location than the others. Perhaps these urban students had a preexisting interest in rural health care and were attracted to the rural nature of Kentucky for their medical education or were influenced by the required rural experiences at the University of Louisville.

The predictive values of the generalist specialty and rural practice prediction rules were better for determining who would *not* be a generalist or establish a rural practice than for determining who would. This is consistent with the conclusions of Bland that students who enter medical school with a preference for primary care may have this preference diminish with time particularly during the clinical years.[3,4] The cultures of medical schools tend to socialize students toward specialty careers and urban practice locations.

These prediction models can be used by admissions committee members to help the University of Louisville School of Medicine reach the goal of having 50% of its graduates select a generalist career and having more of its graduates practice in rural locations. Although the models are weak predictors of generalist specialty choice and rural practice location, these models can be used to limit the number of matriculants who are not likely to select a generalist career or practice in a rural area. However, admission policies alone cannot accomplish the goals of the School. For example, based on the results of this study, to produce a class in which half the graduates would select a career as a generalist, the admissions committee would need to exclude every applicant who was likely to choose a non-generalist career. Since this is not likely to occur, other efforts must be used to compliment admission policies designed to increase the number of graduates who choose generalist career or rural practice locations. These efforts include: (1) recruiting individuals more likely to become generalists or rural physicians than the current pool of applicants; (2) attempting to limit the attrition of future generalists during medical school and residency; and (3) supporting generalist and rural physicians in practice.

It has been suggested that new models should be developed that might better predict an applicant's future.[9] These models would be based on other factors that are known to be associated with a generalist career choice or rural location selection: income expectations, lifestyle preferences, the need for prestige, and so forth.[14,15] However, it is not clear that an admissions committee could actually collect this kind of information and use it in a systematic way to make admission decisions. For example, if either gender or income expectations were found to be an important factor, would it then be appropriate to use it for a decision about the admission of a given applicant? Using demographic data (eg, gender) as admission

criteria may conflict with the principles of equal-protection and due-process.[16]

Any medical school that uses admission policies to achieve goals for its graduates should validate its policies through studies of its own matriculates. Our study supports this assertion, since applicant characteristics associated with the graduates' specialty choice identified by other researchers in other states were not confirmed by this study. Likewise our data may not be relevant to other institutions, but they could use our study methods and modeling approach to develop prediction rules that would be valid for their medical school's applicant pool. Establishing the degree of predictive validity of any intervention, scare in medical education research, is essential if improvements in health care education research are to be realized.[17]

References

1. 1996-1998 State Health Plan. Kentucky Health Policy Board. Frankfort, Kentucky, 1995.
2. Greer DS, Bhak KN, Zenker BM. Comments on the AAMC policy statement recommending strategies for increasing the production of generalists. *Acad Med.* 1995;70:620-641.
3. Bland CJ, Meurer LN, Maldonado G. Determinants of primary care specialty choice: a non-statistical meta-analysis of the literature. *Acad Med.* 1995;70:620-641.
4. Bland CJ, Meurer LN, Maldonado G. Determinants of primary care specialty choice. Rockville, Maryland: Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, Public Health Service, 1994 (NTIS #PB95184776.)
5. Blue AV, Donnelly MB, Harrell-Parr P, Murphy-Spencer A, Rubeck RF, Jarecky RK. Developing generalists for Kentucky. *J Ky Med Assoc.* 1996;94:439-445.
6. Ernst RL, Yett DE. Physician location and specialty choice. Ann Arbor: Health Administration Press 1985.
7. Costa AJ, Schrop SL, McCord G, Gillanders WR. To stay or not to stay: factors influencing family practice residents' choice of initial practice location. *Fam Med.* 1996;28:214-219.
8. Fryer GE, Stine C, Vojir C, Miller M. Predictors and profiles of rural versus urban family practice. *Fam Med.* 1997;29:115-118.
9. Elam CL, Rosenbaum ME, Johnson MMS. Geographic origin and its impact on practice location in Kentucky. *J Ky Med Assoc.* 1996;94:446-450.
10. Kleinbaum DG, Kupper LL, Morgenstern H. Epidemiologic research: principle and qualitative methods. New York: Van Nostrand Reinhold, 1982.
11. Moser BK, Stevens GR. Homogeneity of variance in the two-sample means test. *Amer Statis.* 1992;46:19-21.
12. Hosmer DW, Lemeshow S. *Applied logistic regression.* New York: John Wiley & Sons, 1989.
13. Miller RG. The jackknife: a review. *Biometrika.* 1974;61:1-15.
14. Fincher RE, Lewis LA, Rogers LQ. Classification model that predicts medical students' choices of primary care of non-primary care specialties. *Acad Med.* 1992;67:324-327.
15. Rosenthal MP, Turner TN, Diamond J, Rabinowitz HK. Income expectations of first-year students at Jefferson Medical College as a predictor of family practice specialty choice. *Acad Med.* 1992;67:328-331.
16. Nowacek G, Saches L. Demographic variables in medical school admission. *Acad Med.* 1990;65:140-144.
17. Renger R, Meadows LM. Testing for predictive validity in health care education research: a critical review. *Acad Med.* 1994;69:685-687.

A Disturbing Trend

"Healthcare by its nature is not a mere commodity. . . . Healthcare is fundamentally different from most other goods because it is essential to human dignity and the character of our communities."

— The late Cardinal Joseph Bernadin

"Mounting shadows darken our calling and threaten to transform healing from a covenant into a business contract."

— Committee to Defend Healthcare

Terry held the defibrillator paddles to the patient's chest and once again shocked him with 360 Joules of electricity. Still his heart rhythm remained ventricular fibrillation. His blood pressure was not detectable. Peggy had talked with the attending physician and he agreed that despite all that we had done there was no hope that the patient would survive. We stopped the code blue and shortly thereafter pronounced the patient dead at 2:45 AM on Christmas Day 1982.

We were exhausted but there was no time to sleep. The medicine service at Christ Hospital was quite busy that night. That Christmas Day Terry was the intern on call for the medical ICU and Peggy was the chief medical resident on call for the entire hospital. We would never have worked such long, stressful hours just for money, but the non-material rewards of caring for the sick have always made us proud to call ourselves physicians.

A couple of years after that memorable Christmas Day, we finished our residency, got married and have been practicing this respected profession in the Cincinnati area ever since. Currently we are in the practice of Internal Medicine in Covington, Ky.

Over the past few years we have noted a disturbing trend in this business of caring for the sick of our community. For-profit or market-driven healthcare is very quickly becoming a major controller of healthcare delivered throughout our community and across our country. We feel that this trend not only threatens the integrity of our profession but more importantly threatens the entire system of healthcare provided to our communities.

The past few years have witnessed remarkable growth in for-profit healthcare. Yet despite a booming economy and low unemployment rates, we have also witnessed an increase in the number of uninsured Americans, up to 41.7 million people. This revolution in healthcare has been a quiet one. We feel that the large majority of the public does not realize most of these changes and certainly don't understand their significance.

The purpose of writing this letter and the purpose of a recent publication in the *Journal of the American Medical Association (JAMA)* is to call attention to this major disturbing trend in healthcare. The *JAMA* article was written by a group of physicians and nurses based in Boston, Massachusetts, and articulates some of our concerns. The following are several quotes from this thoughtful publication:

". . . The shift to profit-driven care is at a gallop."

". . . For the public who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly."

". . . Market medicine treats patients as profit centers."

". . . Listening, learning, and caring give way to deal-making, managing, and marketing."

". . . Public resources of enormous worth—non-profit hospitals—built over decades by charity, devoted volunteers and taxes are being taken over by companies responsive to Wall Street and indifferent to Main Street."

". . . The Committee to Defend Healthcare wishes to call attention to the deterioration of care and caring and initiate a colloquy on a future healthcare guided by science and compassion rather than greed."

Christmas Day 1997 we were again on call together. Peggy made rounds at St. Elizabeth South and Terry made rounds at St. Elizabeth North. Thankfully this call day was not nearly as stressful as that Christmas in 1982 spent at Christ Hospital. In 1982 we would often have trouble sleeping at night wondering when the next code blue would be called. Now we still have worried nights concerned about our patients. But now we have the added burden of worrying about our entire healthcare system. We believe now is the time to call a code blue on our current healthcare system. The powers of the marketplace and for-profit medicine may seem like formidable and insurmountable foes but we must rise to the challenge to improve the healthcare delivered to our communities.

We didn't stay awake for 36 hours taking care of sick people Christmas 1982 for the money. We didn't work Christmas Day 1997 just for the money.

The purpose of the practice of medicine is not making the most money for stockholders.

Our hope for our patient in 1982 was that he would wake up to enjoy a better health status. Our hope for 1998 is that our society, our legislators and our profession wake up and act now to "create a healthcare system based on science and compassion rather than greed."

Peggy J. McDannold, MD
Terry A. McDannold, MD

The Drugstore

"I must admit that considerable good can be accomplished by these compulsory pharmacy consultations but much bad material has to be rejected to reach the smaller amount of good that should be adopted."

My office has a party every week that cleans the tortured souls of the party goers and gives the happy energy we need to go forth and solve real problems, relieve the suffering of real patients and go home with a sense of having accomplished a little good. At our party we take an unknowing victim and macerate his persona beyond recognition, throw his remains to the wolves and watch the wolves gleefully satiate themselves. We call our party

Time for Pharmacy Review

We start with the pharmacist's recommendation, like change a calcium channel blocker to an ACE inhibitor. Then we go to the rationale: for "cost effectiveness." This is so irrational it should be embarrassing to the pharmacist.

There is the recommendation to change a medicine the patient has taken successfully for six months for "safety profile." Since the patient's profile has remained safe for six months, this might be a good reason not to change the medicine.

There is the continual urge to decrease psychoactive medicines and this is a very proper thing to try to do but the opinion of nursing must be sought and respected and serious efforts made not to harm the patient by mindless manipulation of medicines.

In the final analysis I must admit that considerable good can be accomplished by these compulsory pharmacy consultations but much bad material has to be rejected to reach the smaller amount of good that should be adopted. The intelligent participation by nursing is essential to reach recommendations for improvement.

So, we thank the pharmacist for his constructive criticism without telling him he is the life of our pharmacy review parties.

A. Evan Overstreet, MD
Editor

Stir What Ya Got!



Jan Crase
KMAA President 1998-99

Following is the Inaugural Address presented April 21, 1998, by Jan Crase, Somerset, as she assumed the Presidency of the Kentucky Medical Association Alliance.

I'll try not to be like the politician making a speech who got a bit carried away, as so many of them do, and spoke for two hours. Finally, he realized what he was doing and said, "I'm sorry I talked so long, I left my watch at home." A voice from the back of the room yelled, "There's a calendar behind you." — Yes, I do have my watch.

It is a pleasure to be here with you. I appreciate so very much all the wonderful support, encouragement, and especially all the kindness you have shown to me.

Physicians are caring people — Physician spouses are caring people — How important is it to care for others?

Angie DeWeese tells a story about the great anthropologist Margaret Mead who dedicated her life to studying ancient cultures. One day a student asked her for the very earliest sign of civilization in *any* given culture. He expected the answer to be a clay pot, or perhaps a fishhook, or a stone for grinding grain. Her answer was, "A healed femur." She explained that no healed femurs are found among savages. You will find skulls crushed by clubs, and temples pierced by arrows, but no healed femurs are found where the law of the jungle, survival of the fittest, reigns. A healed femur shows that someone had to show compassion. Someone had to care for that person with the broken leg while it healed. Someone had to do that injured person's hunting and bring him or her food until that leg healed; therefore the **first sign of civilization** is caring for others. — Nothing happens until someone cares!

We are all privileged to be a part of such a caring profession and such a caring organization. Let me share with you my own personal story about the care and concern of this organization.

Many years ago when my husband graduated from medical school and we moved to Wichita, Kansas, where I didn't know a soul, it was the medical auxiliary who welcomed me and helped me to acclimate to that community, so much so I didn't want to leave. When we moved to Berea, Kentucky, the medical auxiliary was there for me and helped me get involved in community projects right away. Then, when Jim was drafted into the Navy and we moved to Norfolk, Virginia, where, again, I didn't know a soul — you guessed it, the Navy medical auxiliary welcomed me with open arms and again helped me acclimate to a whole new way of life. When moving to Somerset, Kentucky, the medical auxiliary was there again to support me and help me to adjust and get involved in the community. I have learned that medical spouses are involved in everything worthwhile in the community. If at least one of them is not involved in an organization, then don't bother. The auxiliary or alliance as it is called today has been there for me all my married life. It has been a base of support, a supply of friends, and a most caring organization.

You people understand where I'm coming from and what I'm experiencing. You understand phones ringing all night, spouses being up all night going back and forth to the hospital, worrying about a patient. You understand lots of time alone,

late dinners, and going to social events alone. You understand it all because you have been there and done that. My agreeing to serve as your president is a very small way of giving back to the organization that has given so very much to me.

I enter upon my duties as president, however, with a sense of humility. I am, for a short period of time, to be captain of a ship in which every member of the crew is capable of being captain.

Most presidents use some theme or motto for their year of service. Most of these themes sound ideal or imply high goals. Well, mine does not imply either — but somehow I think it fits. It comes from a story about a College President and *Bible* teacher, who while returning home late one night had stopped at a roadside diner in a Texas hill country town to get a quick cup of coffee. Being accustomed to using large amounts of sugar in his coffee, he quickly used all the sugar packets the waitress had left on the table for him, but wanted more. As the waitress came near his table again, he called out, "I want some more sugar, please." The crusty old gal defiantly put her hands on her hips, leaned over toward him and snapped, "Why don't ya stir what ya got!"

When you feel there is a scarcity of sugar or whatever in your life, "Why don't ya stir what ya got." I thought that could be a good slogan for us.

Theodore Roosevelt said, "Do what you can/with what you have/where you are." In other words — stir what ya got!

Doctors are under tremendous stress and being attacked from numerous directions. We all know this stress is not staying in the office, it's going home with the physician and is affecting spouses and families. Both physicians and patients are experiencing more and more frustration as they encounter scarcity and choices. So what are we going to do? How are we going to "stir what we got?" What is our most valuable possession?

What about the fact that we have each other? After all, we're all in this together. We are all a part of this family of medicine. Physicians need support, and we all need each other. There are many divisive forces out there. The old theory of divide and conquer is alive and well and being used by more than one group against the physician. Also there is much adversity and uncertainty in the profession itself. Therefore, it is all the more important that physicians put aside their differences and spouses put aside their differences and all work together to protect physician and patient choices, thereby protecting quality medical care. United we can stand, divided we shall surely fall. Can the Alliance be the glue that helps hold the family of medicine together?

Whatever happens to medicine, happens to you the spouse. Medicine's image, positive or negative, affects you the spouse. High liability insurance rates and adverse medical legislation affect you the spouse. The quality of medical care affects you the spouse. I've heard doctors' spouses say, "I don't want to join the Alliance — it's too much like a ladies' aid society — besides I want my own identity." Well, to those I say, "First of all, when you married a physician you added the identity of being a physician's spouse; whether you like it or not, that came with the package. You can have any other identity you wish, but as long as you are married to a physician, you will also be known as a physician spouse so you might as well join the spouse's organization and get to know others who understand where you are coming from, and who share your unique experiences and problems. Besides, it's an extremely worthwhile organization doing great things for the community, the state, and the nation."

In addition to the warm cozy feeling and support given to us members, the Alliance always looks to the advancement of health and education. It has a long and rich history of 75 years. It was organized in Kentucky in 1923 in Crab Orchard. Over the years this organization publicized multiple public health hazards, fought for better access to health care, distributed information about teen pregnancy, assisted in public vaccination and school health programs, raised funds for medical research and education, and has been active in the political arena.

Today, the Alliance still looks to the advancement of health and education. Its activities fall into four main categories — *AMA/ERF, Health Promotions, Legislative, and Membership.*

AMA/ERF: Kentucky has a rich history of supporting the AMA Education Research Foundation, and hopefully this year we can endow an Alliance scholarship with these funds at both U of L and U of K medical schools.

HEALTH PROMOTIONS: I'll briefly touch on three health projects to be addressed this year.

#1. The Alliance has been involved in many health promotions over the years, but none more significant than SAVE, which stands for "Stop America's Violence Everywhere." This is a nationwide effort of physicians' spouses to combat violence through a wide range of grassroots initiatives. Why is there a need for SAVE?

1. Violence is today's number one health crisis.
2. Violence is one of the most profound yet preventable health epidemics of our time.

3. Violence has replaced disease as the number one killer of children.

Yet, violence is a **chosen** behavior.

A united effort with lots of support accomplishes much more than a single effort. Joining hands and working together with the schools, the government, other non profit organizations and businesses, we **can** Stop America's Violence Everywhere. Shall we carry this program forward in Kentucky this year?

#2. Did you know that according to the September 1993 issue of *American Journal of Public Health*, teachers have a 60% higher mortality from breast cancer than any other professional group? I think we have found a way to reach 45,000 Kentucky teachers plus 40,000 school staff and remind them to get their mammograms. Stay tuned.

#3. Smoking. We're all aware of the health hazards of smoking and the importance of **early** prevention. Please take a look at the SMART program this year and see if you would like to use this in your county.

I think we would agree that **all** these health promotion projects are extremely worthwhile.

LEGISLATIVE: As most of you know, I am especially interested in the legislative process and I encourage you to be involved also. After all, medicine and politics are a family affair. For every law that is passed, there are winners and there are losers. In the political arena you have a choice. You are either a participant or you are a victim. Unfortunately there is no category of spectator. Power does not reside in the profession. It resides with those who take it. What about a political workshop with a "Back to Basics" training? You can't fight a war without an army. Physicians and Alliance soldiers need to receive basic training for combat readiness. Are you ready to "stir what ya got" and accept the responsibility of power?

MEMBERSHIP: Membership is always a challenge in any organization; however, special challenges are facing this one. First of all, about 40% of the medical students today are female, and their male spouses, thus far, are not inclined to join this organization. What can be done about this? Also, in the USA the average length of marriage before divorce is 7 years and married physicians have a 10-20% higher divorce rate than that of the general population. Some states are looking at allowing divorced members to remain on as members. Is this something to consider in the future? Anyway, one of the most successful *techniques* for getting new members seems to be personal contact where each member invites a non-member to join. Tell your own personal story of why you joined the Alliance and what the Alliance means to you. Please, **take the time** to invite a non-member to join. I challenge you to be innovative and increase membership in your own county and help organize at least one other adjoining county.

This organization has tremendous potential and talent. The Alliance is one of the most highly organized and involved health organizations in local communities, the state of Kentucky, and the Nation. When joining efforts with the Medical Association, the potential is awesome; however, potential doesn't amount to a hill of beans if it is not exercised. Will Rogers said, "Even if you're on the right track, you'll get run over if you just sit there." Why not get up and "stir what ya got?"

In today's world of TV and mass media, perception seems to be reality. Doctors' images have been tarnished as a result of perception; therefore, we all need to be more aware of the importance of good public relations.

The special strengths of the Alliance are in public relations and the legislative arena. These tools are extremely valuable to physicians today, so why not work together. There is power in partnership. Besides, it is more fun working together.

Of all the virtues we can learn, one trait is most useful, most essential for survival, and most likely to improve the quality of life — that is **the ability to transform adversity into an enjoyable challenge.** Let's care enough to carve these stumbling blocks into stepping stones. Never doubt that a small number of committed people can change the world — in fact, it is the only thing that can. In other words, "Why don't we stir what we got!"

Jan Crase
KMAA President

Harry W. Carloss, MD Nominated for KMA President-Elect



Harry W. Carloss, MD, has been nominated for the office of President-Elect of the Kentucky Medical Association.

An internist practicing in Paducah, Dr Carloss served as 1st District KMA Delegate for 13 years, from 1985 to 1997; five years as a Trustee, 1992-96; Vice Chair of the Board of Trustees in 1994-95; and Chair of the Board of Trustees in 1995-97. In 1997 he was elected to a one-year term as Vice President. He has served continuously on the KEMPAC Board since 1992. Other current commitments to KMA include service on the Public Education, Professional Liability, Legislative Quick Action, and Cancer Committees, as well as the Physician Advisory Committee to Health Kentucky.

In addition to membership in numerous professional associations, Dr Carloss is a fellow of the American College of Physicians and the Royal Society of Medicine. He is an Associate Clinical Professor of Medicine at the University of Louisville and an Assistant Professor of Internal Medicine at the University of Kentucky.

Dr Carloss is deeply committed and devotes many hours to cancer research, cancer treatment, and Hospice endeavors.

Born in Lexington, Kentucky, Dr Carloss received an undergraduate degree from the University of Kentucky in 1971 and a medical degree from the University of Louisville School of Medicine in 1975. Following an internship and residency at the University of Louisville, he completed a two-year fellowship at Scripps Clinic and Research Foundation, Division of Hematology/Oncology, one year of which he served as Chief Hematology Fellow and Chief Fellow.

Dr Carloss and his wife Barbara have two daughters and one son.

PEOPLE

Sam A. Labib, MD, Whitesburg, was inducted as a fellow of the American Academy of Orthopaedic Surgeons during ceremonies at the Academy's 65th annual meeting in New Orleans. Dr Labib was one of 648 new fellows inducted. With 17,000 active members, the Academy is the largest medical association for musculoskeletal specialists. Its members have completed medical school plus at least 5 years of specialty study in orthopaedics in an accredited residency program, passed a comprehensive oral and written exam, and been certified by the American Board of Orthopaedic Surgery.

Leah J. Dickstein, MD, recently was honored as one of five Louisville-area Women of Distinction for 1998. Dr Dickstein has an international reputation as a physician, psychiatrist, and educator. She grew up in Brooklyn, NY, and met her future husband, **Dr Herbert Dickstein,** while they were in college there. While he was in medical school in Belgium she worked to support them, at one time juggling seven part-time jobs. She took Flemish-language courses in psychiatry and criminology and, after her husband's graduation, became a teacher — first in Belgium, then at an inner-city elementary school in Brooklyn.



In 1966 Dickstein was admitted to the University of Louisville School of Medicine, and remained in Louisville as a physician and teacher. The problem of domestic violence has occupied much of her attention, and she developed a curriculum on sexual harassment, conducting workshops nationally and with all 19 departments at the medical school. She instructs junior medical students on domestic violence, has edited a book on the issue, and serves on the National Advisory Council on Family Violence.

Dr Dickstein is a prolific writer. She is currently finishing four books, including one based on a health-awareness workshop she has conducted for 17 years, and one on the history of women physicians in Kentucky. She also is working on a study of survivors of German concentration camps in World War II.

Allan Tasman, MD, Chairman of the University of Louisville Department of Psychiatry and Behavioral Sciences, has been elected by a wide margin to a term as President-Elect of the American Psychiatric Association beginning in June 1998. He will assume the office of President of the Association in May 1999. The American Psychiatric Association, founded in 1844, is the oldest medical specialty society in the United States. With more than 40,000 members, the APA is the largest organization of psychiatrists in the world.



Dr Tasman's activities with the American Psychiatric Association have spanned 20 years. He is presently completing a two-year term as Vice President. From 1988 to 1992 he chaired the APA's Scientific Program Committee, where he had responsibility for coordinating the entire scientific content of the association's annual meetings. He also has been a member of the APA's Council on Medical Education and Career Development.

A Louisville native and 1973 graduate of the University of Kentucky College of Medicine, Dr Tasman has had a longstanding commitment to excellence in clinical care. He is a graduate of the Western New England Institute for Psychoanalysis in New Haven, Connecticut. Training in psychoanalysis, a specialized form of psychotherapy, requires a lengthy program of course work and supervised clinical work following psychiatric residency. His research, supported by a number of grants over the last 15 years, has focused on the neurophysiology of cognitive process, especially related to alcoholism.

Dr Tasman also is serving in his second term as the President of the American Association of Chairs of Departments of Psychiatry. He is also a past president of the American Association of Directors of Psychiatric Residency Training and of the Association for Academic Psychiatry. Dr Tasman is the only individual in the history of these major academic psychiatry organizations to serve as president of all three.

Dr Tasman is the Deputy Editor of *The Journal of Psychotherapy Practice and Research*, and has been the editor or co-editor of 16 psychiatric textbooks. He is the senior editor of a new comprehensive textbook of psychiatry, entitled *Psychiatry*, published in January 1997. The *New England Journal of Medicine*, in an August 28, 1997 review, called it "the best current textbook of psychiatry."

UPDATES

Parke-Davis and Pfizer, Inc Provide LIPITOR for Health Kentucky

The Parke-Davis division of Warner Lambert Company and Pfizer, Inc will provide LIPITOR® (atorvastatin calcium) tablets free of charge to Kentuckians who live below the federal poverty standards and have no public or private insurance, **Donald C. Barton, MD,** president of Health

Kentucky, Inc, announced recently at a Health Kentucky Board of Directors' meeting.

The free pharmaceuticals are part of a unique voluntary effort by Health Kentucky, Inc to provide low-income Kentuckians access to quality health care. Originally offering physician and hospital services, the program has expanded since its inception in 1984 to include pharmaceutical, dental, hospice, and home health services. Throughout the state more than 1,900 physicians, 500 pharmacies, 150 dentists, every acute care hospital, and 5 pharmaceutical companies volunteer their services to this "safety net" program. Approximately 300,000 Kentuckians are potentially eligible for the services.

Parke-Davis and Pfizer, Inc will provide LIPITOR®, their cholesterol lowering medication, to those patients who qualify for the program. LIPITOR® was discovered and developed by the Parke-Davis Research Division of Warner-Lambert. Parke-Davis and Pfizer, Inc are collaborating on clinical, marketing, and sales support for the product in the US, and broadly in key international markets.

"This medication fills an unmet need in our drug list and will greatly benefit the program's participants, many of whom may have gone without this needed medication," Dr Barton said.

Low-income Kentuckians can access the free prescription drugs through the following procedure:

- To learn whether they qualify, patients must first telephone the statewide toll-free Physicians Care hotline (1.800.633.8100) weekdays between the hours of 8 AM and 4:30 PM.
- To qualify, a patient must have a currently valid Kentucky Physicians Care eligibility form. The form documents that the individual has been appropriately screened as eligible, is without health insurance and is ineligible for such government

FRAUD AND ABUSE AUDITS UNDERWAY

Many physicians around the state are receiving letters from Kentucky's Medicare carrier, Administar, informing physicians they will be coming to audit certain charts. This is part of a nationwide effort initiated by the federal government to audit physician billings. According to the Director of HCFA's Program Integrity Group, the primary reason for the reviews is to come up with a statistically valid survey of physician documentation.

Of course, this does not mean this information will not be turned over to federal or state agencies for further action nor does it preclude their looking for other information. Physicians should review their office policies and procedures regarding documentation, as well as all facets of their practices.

In the past, the government has issued "Special Fraud Alerts," which gave notice to all medical providers, including physicians, of specific practices the government says might raise "red flags" as to whether the law has been violated.

SOME FRAUD ALERTS

- ☐ **Routine waivers of coinsurance and deductibles.** The government indicated that "when providers . . . forgive financial obligations for reasons other than genuine financial hardship of the particular patient, [the provider] may be unlawfully inducing that patient to purchase items or services from them . . ."
- ☐ **Hospital incentives to physicians.** The government indicated that inducements given to physicians by hospitals to ensure referrals may be suspect under the anti-kickback law. Suspect arrangements contained in the Special Fraud Alert include: free or significantly discounted office space or equipment; free or significantly discounted billing services; income guarantees; low-interest loans; and, inappropriately low-cost physician coverage in hospital group insurance plans.
- ☐ **Prescription drug marketing practices.** The government said it was concerned about drug companies conducting marketing activities that go beyond "traditional advertising and educational contacts." An example that may raise "red flags" is when a drug company offers a physician frequent flier miles each time a physician completes a drug company's questionnaire regarding one of its products.
- ☐ **Arrangements regarding the provision of clinical laboratory services that may violate the anti-kickback law.** The first such arrangement dealt with phlebotomy services being performed in physicians' offices by laboratories that are unrelated to traditional laboratory functions. Another type of arrangement concerned "free goods" offered by laboratories to physician offices such as the free pickup and disposal of biohazardous waste products that are unrelated to the laboratory's collection of specimens.

entitlement programs as Medicare and Medicaid.

- Physicians who participate in the Kentucky Physicians Care Program prescribe for qualified patients any of the participating products from the 5 companies.
- The eligible patient takes the prescription to a participating pharmacy and presents identification including a currently valid Kentucky Physicians Care eligibility form.
- The participating pharmacy fills the prescription with the participating companies' products and submits an order for eligibility verification and product replenishment.
- The participating pharmaceutical company will ship product replacement to the participating pharmacy.

"Parke-Davis and Pfizer, Inc's participation will further expand the 'safety net' of indigent care provided through this successful public-private partnership. They're providing a much-needed medication," Dr Barton added.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Robert S Mesirow DO — AN
106 Buena Vista Dr, Ashland 41101
1991, Chicago Col of Osteopathy

Carroll

Herodotos Ellinas MD — IM
1002 Hickory Switch Rd, LaGrange 40031
1992, U of Chicago

Clark

Rebecca O Bartee DO — S
205 Floyd Clay Dr, Winchester 40391
1997, Kirksville Col, Missouri

Fayette

Thomas D Armsey Jr MD — FP
300 Delaney Woods, Nicholasville 40356-8730
1992, Wright State U

Alan C Beckman MD — R
2673 Fireside Cir, Lexington 40513
1988, U of California, Irvine

Barry L Burchett MD — EM
854 McMeekin Pl, Lexington 40502
1976, U of Kentucky

Donald R Douglas MD — AN
280 Pasadena Dr, Lexington 40503
1986, U of Kentucky

Michael J Drass MD — AN
3028 Blenheim Way, Lexington 40503
1992, Penn State

Phoebe D Fisher MD — AN
317 S Mill St, Lexington 40508
1992, U of Pennsylvania

Mark L Gross MD — OPH
3509 Mellinocket Ct, Lexington 40503
1993, U of Kentucky

Henry A Harlamert MD — PTH
3912 Peppertree Dr, Lexington 40513-1331
1991, U of Cincinnati

Firdaus Hashim MD — AN
3900 Crosby Dr Apt 1617, Lexington 40515-1864
1988, Kasturba, India

Michael L McKinney MD — IM
2205 Cascade Way, Lexington 40515-1263
1993, U of Kentucky

Frederick J Michel MD — FP
1221 S Broadway, Lexington 40504
1971, Penn State, Hershey

Mubashir A Qazi MD — IM
333 Waller Ave Ste 100, Lexington 40504
1985, Kyber, Pakistan

Cristin M Rolf MD — PTH
100 Sower Blvd Ste 202, Frankfort 40601-8272
1991, Med Col of Ohio at Toledo

Harold H Rutledge MD — FP
3503 Arden Pl, Lexington 40517
1983, U of Kentucky

Tammy S Sanders MD — OTO
1740 Chandler Ln, Lexington 40504-2390
1992, U of Mississippi

Mark D Scott MD — FP
Kentucky Clinic 0284, Lexington 40536-0284
1989, Southern Illinois U

Stephen Jay Troum MD — ORS
1725 Harrodsburg Rd, Lexington 40504-3601
1991, Bowman Gray of Wake Forest

Alexander E Tzouanakis MD — PUD
166 Pasadena Dr, Lexington 40503-2907
1988, U of Texas, Galveston

Kryder E Van Buskirk III MD — P
4068 Peppertree Dr, Lexington 40513
1992, Med Col of Va

Veronica A Vasicek MD — ORS
1381 Copper Run Blvd, Lexington 40514-2219
1990, Quillen-Dishner, Tennessee

Greg R Wheeler MD — NS
101 Clubhouse Dr, Nicholasville 40356
1990, Wright State U

Graves

Majid Torabi MD — OTO
1547 Waverly Dr, Mayfield 42066-3725
1981, Faculty of Med of Isfahan, Iran

Harlan

Jameel A Butt MD — S
37 Ball Park Rd, Harlan 40831-1701
1971, U of Sind, Pakistan

Jefferson

John M Conner MD — ORS
1941 Deerwood Ave, Louisville 40205-1203
1992, U of Kentucky

Stuart H Hagan MD — EM
6309 Rockingham Ct, Prospect 40059-9341
1992, U of Louisville

Michael J Kelley MD — IM
1710 Cedar Point Rd, La Grange 40031-9766
1993, U of Louisville

Linda Korfhage MD — PTH

6302 Regal Rd, Louisville 40222
1984, U of Louisville

Therese-Anne LeVan MD — PS
3200 Todds Rd Apt 306, Lexington 40509-9494
1989, Rush, Illinois

Henry A Luban MD — IM
2222 Valley Vista Dr, Louisville 40205
1982, U of Vermont

Shannon M McAllister MD — IM
120 Fairmeade Rd, Louisville 40207-3905
1993, U of Louisville

Kenton

James Marcum MD — C
215 Thomas More Pkwy Ste A, Crestview Hills 41017-3493
1991, U of Texas, San Antonio

Knox

Forrest R Carter MD — OBG
HC 89 Box 254, Barbourville 40906
1973, U of Arizona

Logan

Kevin H Rigtrup MD — IM
128 Woodhurst Ln, Russellville 42276
1994, Vanderbilt

Michael P Stevens MD — AN
250 Lindsay Ln, Russellville 42276-9621
1991, U of Oregon

Laurel

Patrice Beliveau MD — ORS
1406 W 5th Street, London 40744
1989, U of Montreal

Marion

Daniel V Hunt MD — ORS
330 Loretto Rd, Ste 400, Lebanon 40033
1990, U of Alberta, Canada

James V Tobin MD — OBG
315 W High St, Lebanon 40033
1975, U of Louisville

Perry

Yu Cho Shih MD — S
401 Annice Way, Hazard 41701
1993, State U of New York, Buffalo

Warren

Sarah A Mayfield MD — IM
1300 Andrea St Ste 206, Bowling Green 42104
1993, U of Louisville

IN-TRAINING

Fayette

Ronald Forrest Koury DO — EM
Jackson Maddux MD — PMR
Andrea Leigh Skaggs MD — FP

Jefferson

Maria T Darrell MD — P
Brian John Williams MD — D
Christopher D Wohltmann MD — S

DEATHS

Ernest Mustgrave, MD
Paintsville
1922-1998

Ernest Mustgrave, MD, a general practitioner, died February 14, 1998. Dr Mustgrave was a 1954 graduate of the University of Puerto Rico School of Medicine and an active member of KMA.

Glenn Bryant, MD
Louisville
1914-1998

Glenn Bryant, MD, a retired OB/GYN, died February 26, 1998. A 1938 graduate of the University of Louisville School of Medicine, Dr Bryant was a life member of KMA.

A. Samuel Warren, III, MD
Lexington
1913-1998

A. Samuel Warren, III, MD, a retired internist, died March 10, 1998. Dr Warren graduated from Vanderbilt University School of Medicine in 1940 and was a life member of KMA.

Joseph Cona, MD
Louisville
1912-1998

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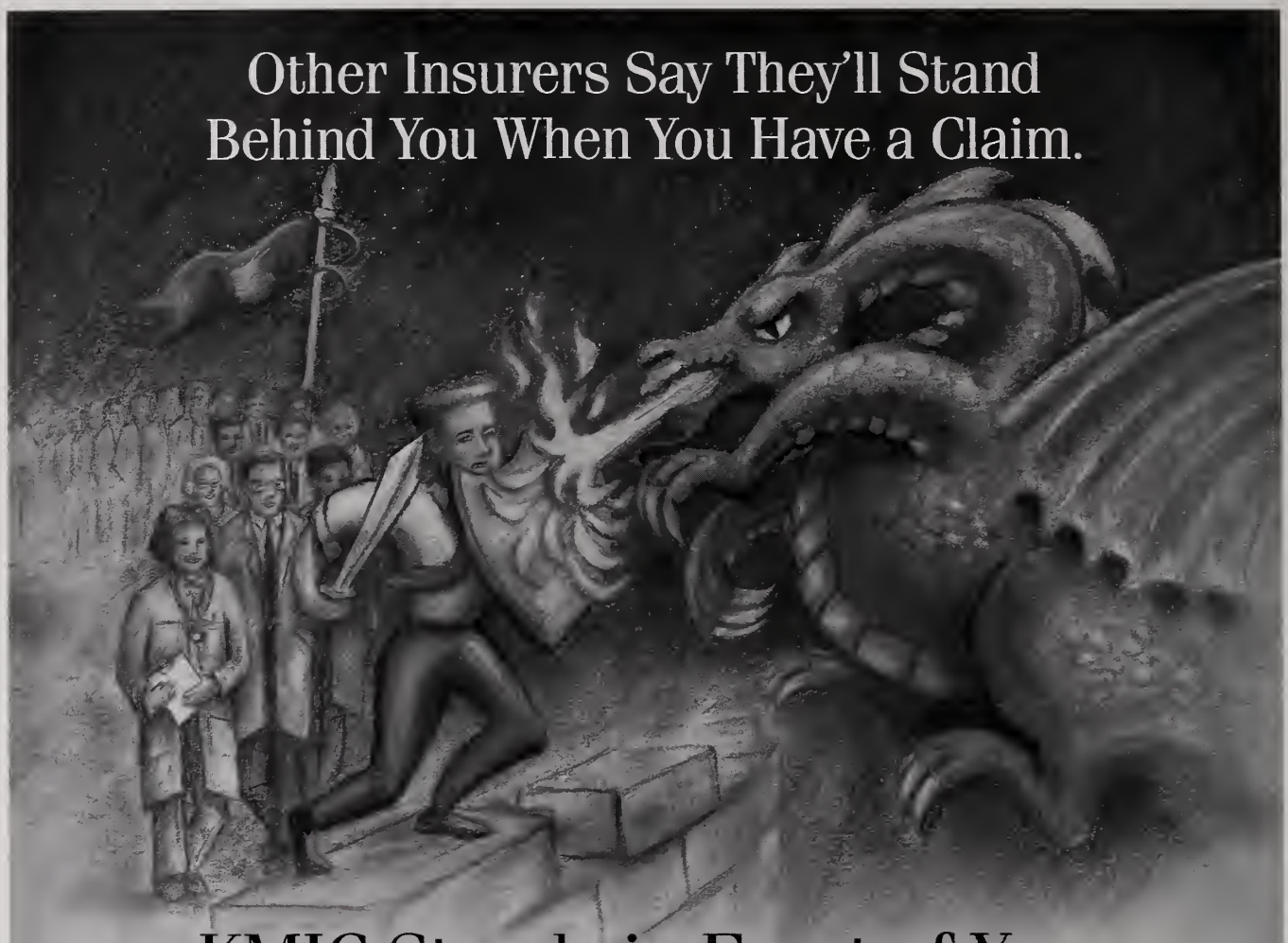


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COVER STORY	The Lateral Chest Radiograph in the Detection of Pericardial Effusion: A Reevaluation *John H. Woodring, MD*	**218**
SCIENTIFIC	Bronchial Foreign Bodies Simulating Endobronchial Malignancy *Kasem Charnvitayapong, MD; Daniel L. Miller, MD; William A. Hymes, MD; Eugene C. Fletcher, MD*	**226**
SPECIAL ARTICLE	Health Care for Kentucky's Uninsured Indigents: The Perspective of Providers in the Kentucky Physicians Care Program *Arch G. Mainous III, PhD; Charles H. Griffith III, MD, MSPH; L. Joyce McCown*	**231**
EDITORIAL	"Fear and Loathing at Fifty" *Jaroslav P. Stulc, MD*	**234**
ASSOCIATION	*Monitoring Medicine* Board of Trustees Spring Board Meeting News	**215** **238** **239**
DEPARTMENTS	President's Page Advertisers' Guide Alliance Page Classifieds Information for Authors	**213** **242** **235** **241** **229**



COVER:
The purpose of the study beginning on page 218 was to evaluate the usefulness of 10 previously published plain film signs for diagnosing pericardial effusion and to determine whether the posteroanterior (PA) or lateral chest radiograph was the better view for detecting pericardial effusion.

Artwork by Lee Wade of Eminence, KY.

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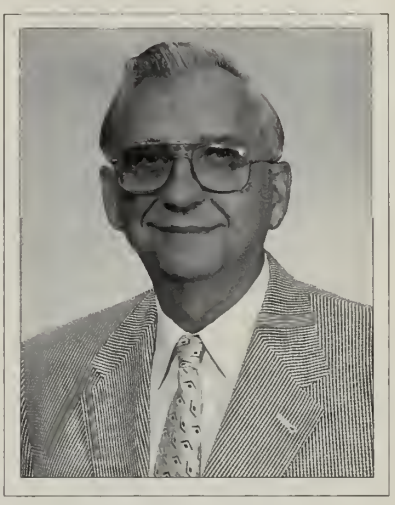
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What Has Organized Medicine Done for Us Lately?



C. Kenneth Peters, MD

Since I have been involved in medicine, I have always been impressed with the work done by the national, state, and local medical associations on behalf of physicians. My experience in working with these organizations makes it puzzling to hear some of my colleagues say things like, "Why should I join? What has organized medicine done for me lately?" The Kentucky General Assembly just completed its work and I can tell you that without the hard work of organized medicine, physicians would have to deal with some very onerous burdens. But I will leave it to others to tell you about the triumphs we had in the legislature. I want to tell you another story about what organized medicine has done for physicians lately.

Many of my colleagues have expressed concern about the content of the new E & M documentation guidelines issued last year. The American Medical Association recently held a meeting in which physicians were given the opportunity to comment on the new guidelines and discuss them with representatives from the federal government. Before I get into what happened at that meeting, let me give you a brief history of how the guidelines were developed.

In 1992, the federal government hired Harvard University to develop a resource-based relative value scale (RBRVS) for Medicare payments. Two approaches to developing this system were discussed. The first approach, which was favored by the Harvard researchers, involved a time-based set of codes in which physicians would report the amount of time spent with the patient and payment would be generated based on that time. The second approach, which was favored by organized medicine, involved a richer set of codes that reflected the clinical content of the service, as well as the site of the service and general nature of the physician/patient relationship.

Content-based codes were accepted. However, the federal government insisted that if there were going to be content-based codes, there must be a means of documenting services to determine whether the services being reported were actually being provided. The government, without physician input, developed a set of documentation requirements for implementation in 1993. Upon review of those requirements, however, organized medicine determined they were unacceptable and successfully argued for their withdrawal. Part of the agreement to settle the issue included a promise from medicine to participate in a process to develop appropriate documentation guidelines.

In 1994, the National Medical Specialty Societies, coordinating through the CPT Editorial Panel, developed an initial set of documentation guidelines. Based on numerous requests, the guidelines were expanded by the development of "single system examinations" to insure that specialists and primary care physicians alike could clearly report level 4 and 5 services. The original 1994 guidelines, plus the single system and general multi-system examination definitions, basically constituted the 1997 E & M guidelines required by the federal government. When these new codes were released, many physicians expressed concern over their content, which led to the recent meeting coordinated by the AMA.

There are a few physicians who believe organized medicine should not work with the government and oppose the coding system. I disagree. The government has said it will institute a coding and documentation system with or without the input of physicians. 3M has developed such a coding system that could be used by the government and would have no input from physicians. The best way we as physicians can ensure that a proper system of coding and documentation is created is to have organized medicine involved in the process.

Physicians provided many constructive comments regarding the proposed documentation guidelines.

These comments said the proposed guidelines were overly complex; impractical for daily application; untested; cause patient care to suffer; and, force needless care. Based on these comments, the guidelines will be changed. A summary of some of these changes are outlined below.

So, what has organized medicine done for us lately? It has prevented the government from imposing an unworkable system of coding and documentation. It has ensured that physicians have input into the design and implementation of the system. And, it has worked quickly to ensure changes were made when physicians found the documentation guidelines too burdensome. Whatever one might think of the final product, I would rather see physicians involved in the process rather than do nothing and allow the process to take place without our input. For such input, we must have the involvement of organized medicine.

C. Kenneth Peters, MD
KMA President

Summary of Proposed "New Framework" for Evaluation and Management (E&M) Documentation Guidelines

These proposed changes to the 1994 and 1997 Evaluation and Management (E&M) documentation guidelines respond directly to the many specific comments received by the AMA from components or organized medicine and others. They reflect a new framework for documentation guidelines developed by a work group of the CPT Editorial Panel supported by AMA and HCFA staff. They are a work in progress and subject to change.

Summary of Changes

- *Shorten* the document substantially.
- Emphasize that a code may be selected and documented based on *counseling/coordination of care time alone*, without reference needed to any other dimensions of code selection (ie, history, examination, complexity of medical decision making).
- Emphasize that, for *established patients*, only two of the three key components need be performed (ie, history, examination, complexity of medical decision making).
- Simplify *history* selection by allowing documentation of two of the three history areas (HPI, ROS, and PFSH) instead of requiring all three to be documented.
- Add a clear note that, when a *history* can not be obtained due to specific patient conditions (eg, inability to communicate urgent, emergent situation, etc), the history is deemed "comprehensive" for coding and documentation purposes.
- Simplify *examination* criteria and enhance their clinical flexibility by eliminating forced and artificial distinctions between general multi-system exams and single system exams and eliminating confusing shaded and un-shaded boxes.
- Eliminate confusing *examination* instructions that take the form of "perform all elements and document 2 elements."
- Simplify the *medical decision* making section by eliminating one level (low complexity) — the proposed levels are straightforward, moderate, and high complexity.
- Further simplify the *medical decision* making section by allowing the highest complexity element, (ie, the number of diagnoses/risk of complications, diagnostic procedures/tests and or data to be reviewed, or management options) to drive selection of the level of decision making. This change eliminates the need to make a separate selection from the table of risk and then entering that decision into another matrix.

NEWS FOR KENTUCKY PHYSICIANS

HB 315 HIGH RISK DIAGNOSTIC CODES BEING IMPLEMENTED

The Guaranteed Acceptance Program (GAP) is an integral part of HB 315, the Health Insurance Reform legislation adopted by the 1998 Kentucky General Assembly. The GAP will include 28 high risk conditions at the outset. KMA has been meeting with the Commissioner of Insurance (COI) and other groups to establish levels of risk or severity of condition under the various designated high risks. In the future, the Commissioner may designate additional diagnosis for the GAP if sufficient information is presented by providers, carriers, or others. The General Assembly allocated $15.8 million to fund GAP. At the outset two carriers, Blue Cross-Blue Shield and Humana, will insure high risk patients. Under HB 315, the COI, by regulation, will establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

(1) Codes in the most recent version of the "ICD" that correspond to the medical conditions in the below listed diagnoses and the costs for administering treatment for the conditions.
(2) The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the COI, the scoring scale for which shall be established by the COI.

The high risk medical conditions are:
AIDS, angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease.

The COI is interested in comments on:

- The level of severity of the specified diagnosis that should be considered high cost and the corresponding ICD-9 Code.
- Whether additional diagnoses should be added to the list of high cost conditions, and if so, the additional diagnoses and severity levels that should be added and reasons for the additions. The COI has indicated that he does not intend to add to the diagnosis list unless a compelling interest to do so is presented.

The KMA is working with specialists and subspecialists, both in private practice and medical schools, to establish proper assignment of codes. Despite out-of-state insurance companies lobbying, under the guise of "promoting competition," the 1998 General Assembly refused to adopt amendments that would have permitted insurers to determine "high risk" or grant "carte blanche" in designating risk, rates, severity codes, and determining whether to insure an applicant.

The General Assembly also adopted a KMA amendment prohibiting discriminatory payments to providers treating patients insured by GAP. Providers under the GAP will be reimbursed at rates that are no less favorable than the rates paid to the comparable providers for services delivered to enrollees who do not have a high cost condition.

The KMA is unsure as to the exact process of implementing the regulations for GAP, although July 1, 1998, is the target date. Commissioner George Nichols is involving all parties in implementing the GAP.

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The Lateral Chest Radiograph in the Detection of Pericardial Effusion: A Reevaluation

John H. Woodring, MD



The purpose of this study was to evaluate the usefulness of 10 previously published plain film signs for diagnosing pericardial effusion and to determine whether the posteroanterior (PA) or lateral chest radiograph was the better view for detecting pericardial effusion. A retrospective study of 100 consecutive adult patients with pericardial effusions confirmed by echocardiography and/or computed tomography was undertaken. Five signs were found to be useful in detecting pericardial effusion on plain films, and the lateral chest radiograph was found to be better than the PA view in detecting pericardial effusion. The water-bottle configuration, widening of the carinal angle, and the differential-density sign were helpful in diagnosing pericardial effusion on the PA view. However, these signs were only seen in moderate-to-large effusions. The displaced epicardial fat pad sign and the posteroinferior bulge sign on the lateral view improved the detection of moderate-to-large pericardial effusions, and were also present in many of the cases with small pericardial effusions. Recognition of specific signs of pericardial effusion on the lateral chest radiograph may significantly improve the plain film detection of pericardial effusion.

Little has been written about the plain film diagnosis of pericardial effusion since the classic articles on the displaced epicardial fat pad sign by Lane and Carsky[1] and Carsky et al.[2,3] Lane and Carsky in 1968 reported that a displaced epicardial fat pad sign was present on the lateral chest radiograph of 65% of patients with large pericardial effusions.[1] Later, in a follow-up study in which small pericardial effusions were included, Carsky et al found a displaced epicardial fat pad sign in 52% of cases.[2,3] They considered the displaced epicardial fat pad sign to be the best plain film sign of pericardial effusion and the lateral radiograph to be the best view for detecting pericardial effusion.

However, others have not found the chest radiograph to be a useful tool in the diagnosis of pericardial effusion. Manyari et al,[4] using an enlarged cardiac silhouette, straightening of the left heart border, hyperacute right cardiophrenic angle, and a displaced epicardial fat pad as signs of pericardial effusion, performed a study comparing posteroanterior (PA) and lateral chest radiographs to echocardiography in detecting pericardial effusion. They found that only 20% of cases of pericardial effusion were detected on chest radiographs and they concluded that chest radiographs were unsatisfactory for detecting pericardial effusion. As a result, chest radiography is currently considered to be a poor detector of pericardial effusion, and little emphasis is placed upon the recognition of plain film signs of pericardial effusion. It is doubtful that even 20% of cases of pericardial effusion are detected on chest radiographs today.

In 1920, Holmes[5] reported that one of the best fluoroscopic signs of pericardial effusion was a characteristic alteration of the posteroinferior aspect of the cardiac silhouette in the lateral view in which the posteroinferior margin of the cardiac silhouette bulged posteriorly and inferiorly toward the spine forming an obtuse angle with the left hemidiaphragm. Shanks and Kerley,[6] in 1962, referred to this sign as the posteroinferior bulge sign and indicated that it was the earliest radiographic sign of pericardial effusion. After three thorough searches of the literature pertaining to pericardial effusion, I have been unable to find any subsequent mention of this sign of pericardial effusion in the literature.

Over the last few years, I have noticed that the posteroinferior bulge sign is present in many cases of pericardial effusion and is occasionally the only plain film abnormality in cases of small pericardial effusion. This has led me to perform a retrospective study of the plain film signs of pericardial effusion to determine whether or not the PA or lateral chest radiograph was the better view for detecting pericardial effusion, and to see which plain film signs were best for diagnosing pericardial effusion.

Subjects and Methods

The study group consists of 100 consecutive adult patients who had proven pericardial effusion and both PA and lateral chest radiographs. Adult patients who had only portable supine anteroposterior chest radiographs, and pediatric cases were not included in the study.

There were 53 women and 47 men ranging in age from 19 to 85 years. The cause of pericardial effusion in these 100 cases was as follows: end-stage renal disease with uremic pericarditis in 27; metastatic carcinoma in 17; postpericardiotomy syndrome in 13; congestive heart failure in 10; non-Hodgkin's lymphoma in 7; viral pericarditis in 7; bacterial pericarditis in 3; postmyocardial infarction syndrome in 3; tuberculous pericarditis, scleroderma, cardiac transplant rejection, and postoperative intrapericardial hemorrhage in 2 cases each; and invasive aspergillosis, blunt chest trauma, dis-

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secting aortic aneurysm, superior vena caval obstruction, and postoperative biliary fistula in one case each.

The diagnosis of pericardial effusion was confirmed by echocardiography (ECHO) in 73 of the 100 cases, by computed tomography (CT) of the thorax in 22, and by both CT and ECHO in 5. The size of the pericardial effusion was subjectively quantitated as small in 37 and moderate-to-large in 63.

The PA and lateral chest radiographs of all 100 patients were evaluated for the following 10 signs of pericardial effusion: enlarged cardiac silhouette,[7] water-bottle configuration of the cardiac silhouette on the PA view,[7] hyperacute right cardiophrenic angle,[5,7] loss of the retrosternal clear space,[7] widened carinal angle in the absence of signs of left atrial enlargement,[8] straight left heart border,[7] differential-density sign,[9,10] displaced epicardial fat pad sign,[1-3,7,11-14] posteroinferior bulge sign,[5,6] and decreased pulmonary vascularity.[7]

Enlargement of the cardiac silhouette, hyperacute right cardiophrenic angle, loss of retrosternal clear space, straight left heart border, and decreased pulmonary vascularity were considered to be nonspecific signs of pericardial effusion. Five signs, including the posteroinferior bulge sign, displaced epicardial fat pad sign, water-bottle configuration, widened carinal angle, and the differential-density sign, were considered to be relatively specific for pericardial effusion. The analysis of data concerned primarily the 5 specific signs of pericardial effusion.

The presence or absence of signs of pericardial effusion was recorded in each case. The cases were then divided into 2 groups based upon the size of the pericardial effusion. In both the 63 cases with moderate-to-large pericardial effusions, and the 37 with small effusions, the number of cases demonstrating the displaced epicardial fat pad sign, water-bottle configuration, widened carinal angle, or differential-density sign was recorded. Following this, the posteroinferior bulge sign was added as a sign of pericardial effusion and the number of cases demonstrating one or more of these 5 signs was recorded.

Results

The chest radiograph was abnormal in all 100 cases. The cardiac silhouette was enlarged in 89%, the posteroinferior bulge sign was present in 87%, there was loss of the retrosternal clear space in 53%, the displaced epicardial fat pad sign was present in 50%, the water-bottle configuration was seen in 40%, a hyperacute right cardiophrenic angle was present in 28%, the carinal angle was widened in 18%, the left heart border was straight in 18%, the differential-density sign was present in 13%, and diminished pulmonary vascularity was seen in 4% of the cases.

In the 63 cases of moderate-to-large pericardial effusions, all 5 specific signs of pericardial effusion were encountered. The water-bottle configuration was present in 40 (63%), the displaced epicardial fat pad sign was present in 36 (57%), a widened carinal angle was present in 18 (29%), the differential-density sign was present in 13 (21%), and the posteroinferior bulge sign was present in 59 (94%) of the 63 cases. When the water-bottle configuration, displaced epicardial fat pad sign, widened carinal angle, and differential-density sign were used as signs of pericardial effusion, specific signs of pericardial effusion were present in 56 (89%) of the 63 cases. When the posteroinferior bulge sign was added, specific signs of pericardial effusion were present in 63 (100%) of the 63 cases.

In the 37 cases with small pericardial effusions, only 2 specific signs of pericardial effusion were encountered. The displaced epicardial fat pad sign was present in 14 (38%), and the posteroinferior bulge sign was present in 28 (76%) of the 37 cases (Figures 1-4). When only the displaced epicardial fat pad sign was used as a sign of pericardial effusion, the diagnosis was apparent on the plain films in 14 (38%) of the 37 cases; however, when the posteroinferior bulge sign was added, specific signs of pericardial effusion were present in 31 (84%) of the 37 cases.

The lateral chest radiograph was better than the PA chest radiograph in detecting pericardial effusion. Of the specific signs of pericardial effusion, the displaced epicardial fat pad sign and posteroinferior bulge sign were only seen or were best seen on the lateral view. These signs were present in 50% and 87% of the cases, respectively, and were often present in cases of small pericardial effusion (Figures 1-4). The water-bottle configuration, widened carinal angle, and differential-density sign were only seen or were best seen on the PA view, and were present in 40%, 18%, and 13% of the cases, respectively. These signs were present only in moderate-to-large effusions.

Discussion

The results of this study indicate that PA and lateral chest radiographs are almost always abnormal in

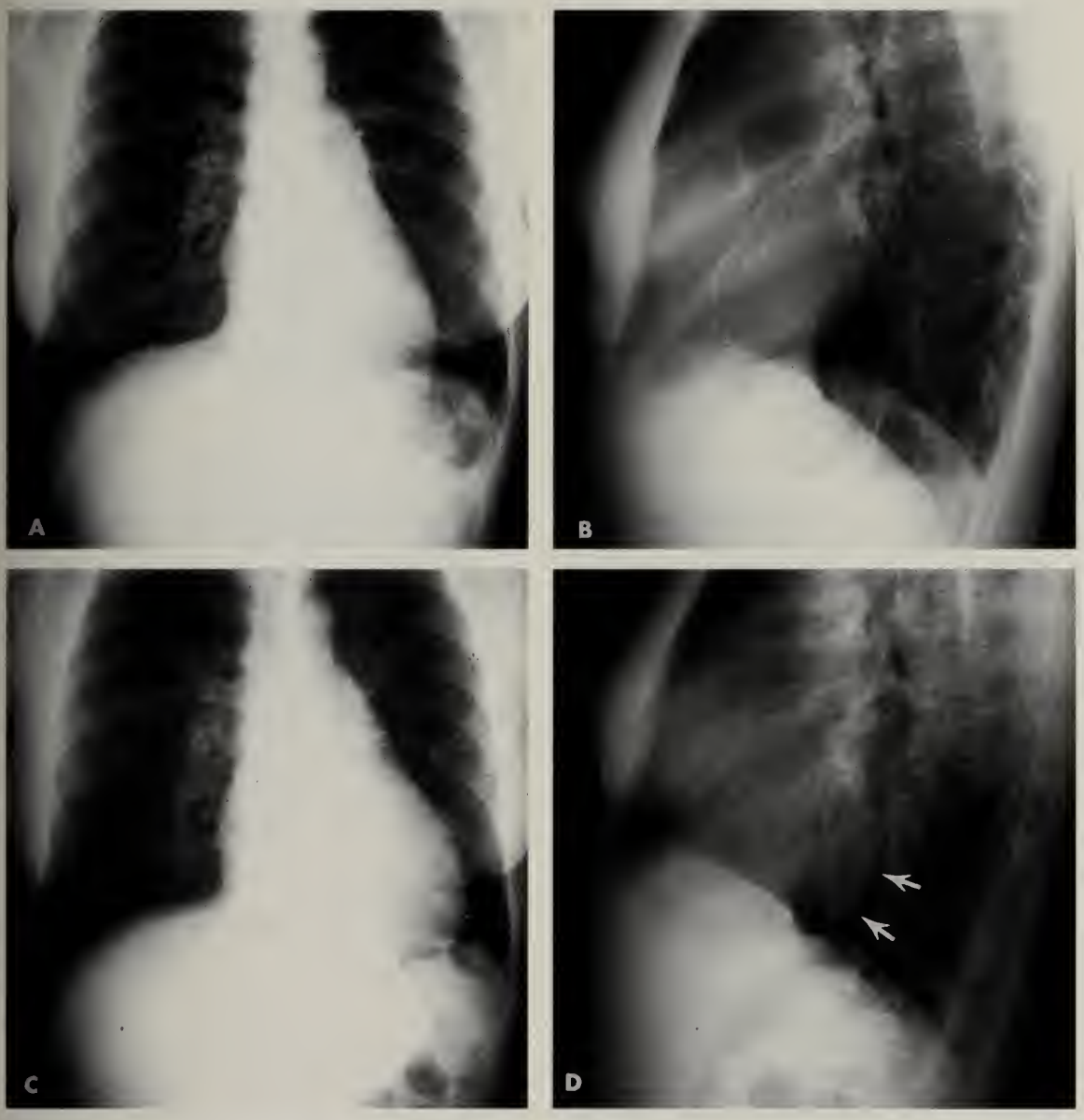


Figure 1 — Small pericardial effusion secondary to uremic pericarditis. Baseline PA (A) and lateral (B) chest radiographs of a 36-year-old woman with chronic renal failure show a cardiac silhouette of normal size and shape. After the development of uremic pericarditis, the PA chest radiograph (C) shows mild, nonspecific enlargement of the cardiac silhouette. The lateral view (D), however, shows a posteroinferior bulge sign. The posterior margin of the cardiac silhouette is more vertical in orientation, and the posteroinferior margin of the cardiac silhouette bulges downward toward the left hemidiaphragm and spine (arrows). ECHO confirmed small pericardial effusion.

cases of pericardial effusion. Unfortunately, many of the signs of pericardial effusion, including an enlarged cardiac silhouette, hyperacute right cardiophrenic angle, loss of retrosternal clear space, and straightening of the left heart border are nonspecific and are unlikely to evoke a prospective diagnosis of pericardial effusion. Furthermore, decreased pulmonary vascularity in pericardial effusion is very rare. The previously reported poor ability of plain films to detect pericardial effusion is likely due, at least in part, to heavy reliance on nonspecific or uncommon signs. However, Meszaros[7] suggests that any rapid enlargement in size of the cardiac silhouette should suggest the possibility of pericardial effusion.

Familiarity with specific signs of pericardial effusion might improve the plain film detection of pericardial effusion. Five signs are relatively specific for pericardial effusion, including the water-bottle configuration of the cardiac silhouette,[7]

widening of the carinal angle in the absence of signs of left atrial enlargement,[8] the differential-density sign,[9,10] a displaced epicardial fat pad,[1,3,7,11-14] and the posteroinferior bulge sign.[5,6] The water-bottle configuration, widened carinal angle, and differential-density sign are seen predominantly or only on the PA view, while the displaced epicardial fat pad sign and posteroinferior bulge sign are best seen or are only seen on the lateral view.

The classic water-bottle configuration of the cardiac silhouette on the PA view is relatively specific for pericardial effusion and is seen only rarely in other conditions such as Ebstein's anomaly or rheumatic tricuspid valve disease.[7] The water-bottle configuration was seen in 40% of the cases in this study. The sign was present in 63% of moderate-to-large pericardial effusions, but did not occur in any of the small pericardial effusions.

A widened carinal angle on the PA view may occur in pericardial effusion, left atrial enlargement, subcarinal lymphadenopathy, and bronchogenic cyst; however, when the cardiac silhouette is enlarged and the carinal angle is widened in the absence of signs of these other conditions, particularly those of left atrial enlargement, the diagnosis of pericardial effusion is relatively certain.[8] A widened carinal angle was present in 18% of the cases in this study. The sign was seen in 29% of the moderate-to-large pericardial effusions, but did not occur in any of the small pericardial effusions.

Spooner et al,[10] and Tehranzadeh and Kelley,[9] described cases of pericardial effusion in which the heart was surrounded by less dense fluid within the pericardial sac. This sign, which is known as the differential-density sign, is also relatively specific for pericardial effusion. It may be seen on either the PA or lateral view, but is usually best seen on the PA view.[9,10] The differential density sign was found in 13% of the cases in this study. Again, the sign occurred in 21% of the moderate-to-large pericardial effusions, but did not occur in any of the small pericardial effusions.

It is apparent that the PA view of the chest is unlikely to show specific signs of pericardial effusion unless the volume of pericardial effusion is sizeable. However, emphasis should be placed on the recognition of the water-bottle configuration of the cardiac silhouette as an aid to the diagnosis of moderate-to-large pericardial effusions. A widened carinal angle and the differential-density sign may occasionally be helpful.

Kremens[12] and Torrance,[11] in 1955 were the first to note that the normal subepicardial fat, or epicardial fat pad, often allowed the pericardial shadow, composed of the apposed layers of parietal and visceral pericardium, to be visibly separable from the heart on plain films. Kremens,[12] and later Jorgens et al,[13] Lane and Carsky,[1] and Carsky et al[2,3] found that the normal thickness of the pericardial shadow was 1-2 mm, and that pericardial effusion was likely if the thickness of the pericardial shadow exceeded 2 mm.

The normal pericardial shadow may be visualized occasionally on PA radiographs, but is usually best seen in front of the heart on lateral

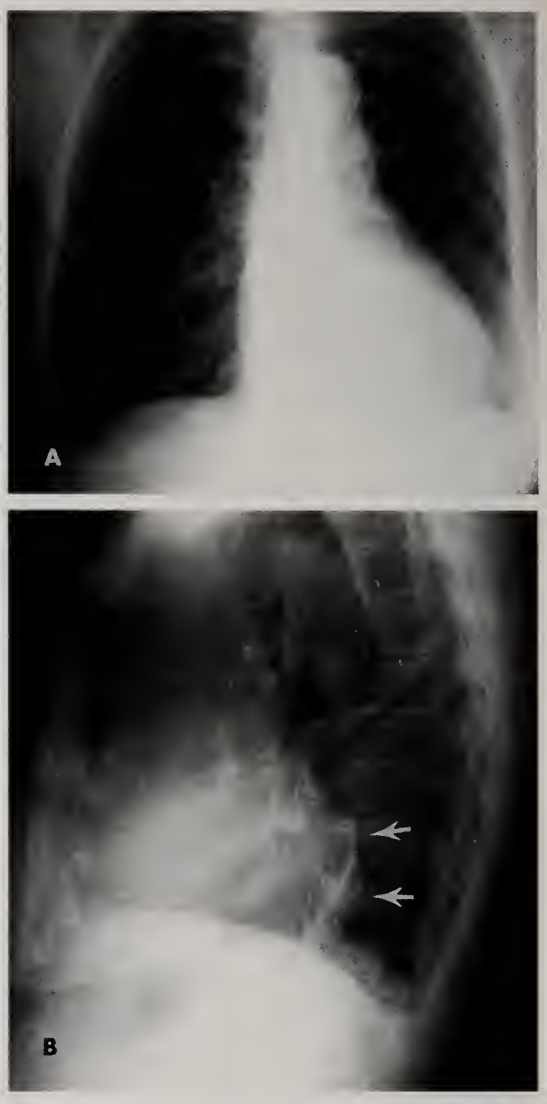


Figure 2 — Small pericardial effusion secondary to uremic pericarditis. In this 55-year-old woman with end-stage renal disease, the PA chest radiograph (A) shows mild, nonspecific enlargement of the cardiac silhouette. The lateral view (B) shows a prominent posteroinferior bulge sign in which the posteroinferior margin of the cardiac silhouette bulges downward and posteriorly (arrows) and overlaps the spine. ECHO confirmed small pericardial effusion.

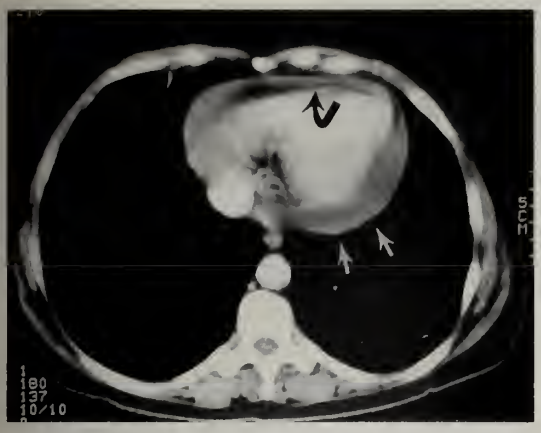


Figure 3 — CT of the thorox in a 48-year-old womon with metostotic corcinomo of unknown primary site shows o smoll pericordiol effusion. Note predominont occumulotion of fluid in the posteroinferior pericardiol recess (white arrows), which explains the formotion of the posteroinferior bulge sign. Pericardial effusion in the onterior portion of the pericardium is seen onterior to the epicordiol fat pod (curved block arrow). The collection of fluid onterior to the epicardial fat pad couses the fat pad to oppeor inwordly disploced within the cardiac silhouette on the laterol chest rodiogroph.

chest radiographs.[1-3] The accumulation of fluid within the pericardial sac separates the visceral and parietal layers of the pericardium and produces visible widening of the pericardial shadow.[1-3,12-14] Although the epicardial fat pad remains in its normal location, the widening of the pericardial shadow causes the epicardial fat pad to appear inwardly displaced within the cardiac silhouette, and this sign is therefore referred to as the displaced epicardial fat pad sign.[1-3,12-14]

Lane and Carsky in 1968 reported that a displaced epicardial fat pad sign was present on the lateral chest radiograph of 65% of patients with large pericardial effusions.[1] Later, in a follow-up study in which small pericardial effusions were included, Carsky et al found a displaced epicardial fat pad sign in 52% of cases.[2,3] The sign was seen on the lateral chest radiograph in 41%, on the PA view in 23%, and on both views in 12% of cases.[2,3] They considered the displaced epicardial fat pad sign to be the best plain film sign of pericardial effusion and the lateral chest radiograph to be the best view for detecting pericardial effusion. False-positive diagnoses may occasionally occur from pericardial thickening without effusion,[15] anterior mediastinal masses,[16] and cardiac levorotation.[17]

In this study the displaced epicardial fat pad sign was seen almost exclusively on the lateral view, but was also seen on the PA view in a few cases. A displaced epicardial fat pad sign was present in 50% of the cases. The sign was noted in 57% of the moderate-to-large pericardial effusions, and was also seen in 38% of the small pericardial effusions (Figure 4).

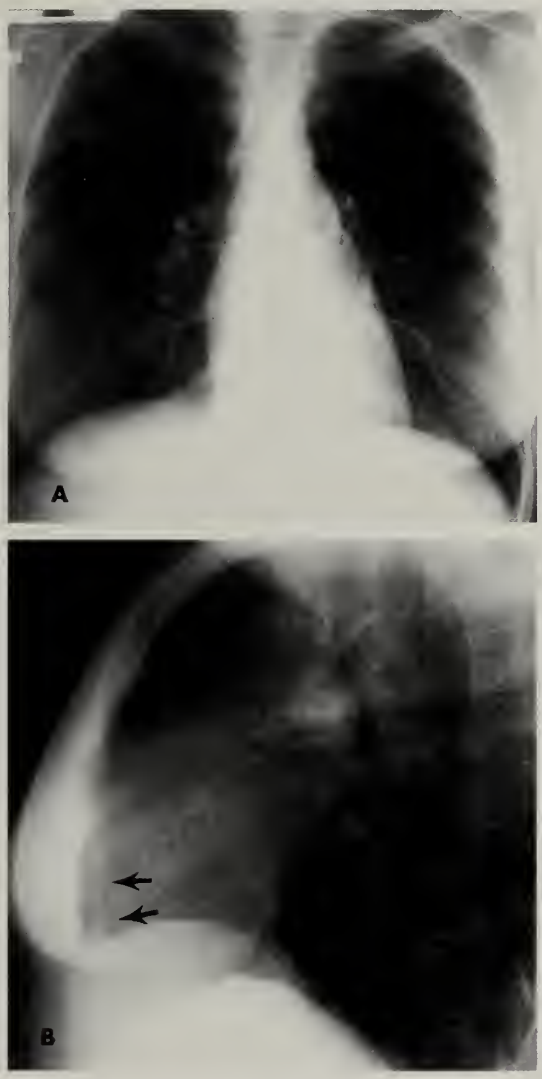


Figure 4 — Small pericordiol effusion secondary to virol pericarditis. On the PA chest rodiogroph (A) the cordioc silhouette is of normol size ond shope. On the loterol view (B) there is a disploced epicardiol fot pod sign with thickening of the anterior pericordiol shodow to 4 to 5 mm (orrows) anterior to the epicordiol fot pad. ECHO confirmed small pericordial effusion.

The posteroinferior bulge sign, first described by Holmes[5] in 1920, appears to be the best sign of pericardial effusion. Studies of pericardial fluid distribution have shown that pericardial effusion usually accumulates predominantly along the diaphragmatic surface of the heart and in the posteroinferior pericardial recess[5,6,18] (Figure 3). In early pericardial effusion, the normal acute angle formed by the posteroinferior cardiac margin and the left hemidiaphragm is lost, and the posterior aspect of the cardiac silhouette assumes a vertical orientation[5,6] (Figure 1). As the effusion increases in size,

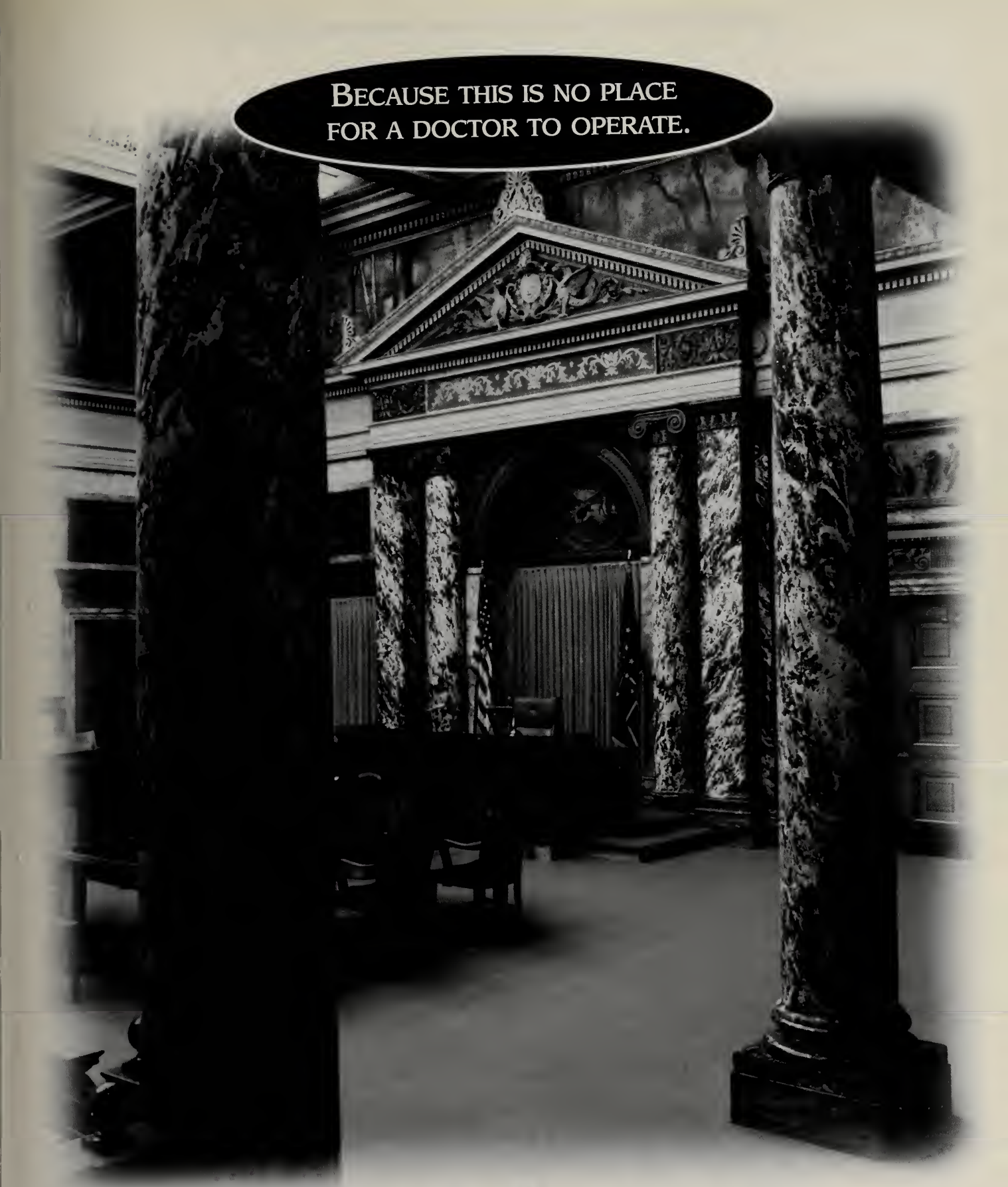
the posteroinferior margin of the cardiac silhouette bulges posteriorly and inferiorly toward the spine forming an obtuse angle with the left hemidiaphragm[5,6] (Figure 2). The sign is particularly useful in diagnosing pericardial effusion when comparison with prior chest radiographs shows that the posteroinferior bulge in the cardiac silhouette is an acute change (Figure 1). Left ventricular dilatation may alter the posterior contour of the cardiac silhouette; however, the left ventricle usually does not dilate acutely, and the angle formed by the dilated left ventricle and left hemidiaphragm usually remains acute.

In this study the posteroinferior bulge sign was present in 87% of the cases. It was seen in 94% of the moderate-to-large pericardial effusions, and was present in 76% of small pericardial effusions (Figures 1 and 2). The sign is not always present since pericardial effusion may occasionally accumulate anterior to the heart[19] or along the right heart border.[6,20] However, inclusion of the posteroinferior bulge sign as a criterion for the diagnosis of pericardial effusion could significantly increase the detection of pericardial effusion on plain films.

In summary, the plain film diagnosis of pericardial effusion can be improved by the recognition of 5 specific signs of pericardial effusion. On the PA view the best signs of pericardial effusion are the water-bottle configuration, widening of the carinal angle, and the differential-density sign. Unfortunately, these signs are only seen in moderate-to-large effusions. The lateral chest radiograph is the better view for detecting pericardial effusion. The displaced epicardial fat pad sign and the posteroinferior bulge sign significantly improve the detection of moderate-to-large pericardial effusions, and are present in many cases of small effusions as well.

References

1. Lane EJ Jr, Carsky EW. Epicardial fat: lateral plain film analysis in normals and in pericardial effusion. *Radiology.* 1968; 91:1-5.
2. Carsky EW, Mauceri RA, Azimi F. The epicardial fat pad sign: analysis of frontal and lateral chest radiographs in patients with pericardial effusion. *Radiology.* 1980;137:303-308.
3. Carsky EW, Azimi F, Mauceri R. Epicardial fat pad sign in the diagnosis of pericardial effusion. *JAMA.* 1980;244:2762-2764.
4. Manyari DE, Milliken JA, Colwell BT, Burggraf GW. Detection of pericardial effusion by chest roentgenography and electrocardiography versus echocardiography. *Can Med Assoc J.* 1978;119:445-450.
5. Holmes GW. The radiographic findings in pericarditis with effusion. *Am J Roentgenol.* 1920;7:7-15.
6. Shanks SC, Kerley P, eds. *A Text-book of the X-ray Diagnosis by British Authors in Four Volumes,* 3rd ed. Vol 2. Philadelphia, Pa: Saunders; 1962:231-236.
7. Meszaros WT. *Cardiac Roentgenology: Plain Films and Angiographic Findings.* Springfield: Charles C. Thomas; 1969: 213-232.
8. Chen JTT, Putman CE, Hedlund LW, Damash NS, Roberts L. Widening of the subcarinal angle by pericardial effusion. *AJR.* 1982;139:883-887.
9. Tehranzadeh J, Kelley MJ. The differential density sign of pericardial effusion. *Radiology.* 1979;133:23-30.
10. Spooner EW, Kuhns LR, Stern AM. Diagnosis of pericardial effusion in children: a new radiographic sign. *AJR.* 1977; 128:23-25.
11. Torrance DJ. Demonstration of subepicardial fat as an aid in the diagnosis of pericardial effusion or thickening. *Am J Roentgenol Rad Therapy Nuc Med.* 1955;74:850-855.
12. Kremens V. Demonstration of the pericardial shadow on the routine chest roentgenogram: a new roentgen finding — preliminary report. *Radiology.* 1955;64:72-80.
13. Jorgens J, Kundel R, Lieber A. The cinefluorographic approach to the diagnosis of pericardial effusion. *Am J Roentgenol Rad Therapy Nuc Med.* 1962;87:911-916.
14. Wang K, Hodges M. Detection of normal pericardium and of pericardial effusion in the lateral chest radiograph. *Circulation.* 1996;93:1254.
15. Engle RB, Upham AT. Positive epicardial fat pad sign without pericardial effusion. *JAMA.* 1982;247:1695.
16. Demos TC, Cardella RG, Moncada R, Reynes CJ, Love L, Churchill RJ. Epicardial fat sign due to extrapericardial disease. *AJR.* 1983;141:289-291.
17. Hirji MK, Johnson MA, Hennig RC. Cardiac levorotation: a cause of false-positive epicardial fat pad sign. *Radiology.* 1986;161:659-660.
18. Soulen RL, Lapayowker MS, Cortes FM. Distribution of pericardial fluid: dynamic and static influences. *Am J Roentgenol Rad Therapy Nuc Med.* 1968;103:583-588.
19. Gale ME, Kiwak MG, Gale DR. Pericardial fluid distribution: CT analysis. *Radiology.* 1987;162:171-174.
20. Green B, Zornoza J, Ricks JP. Eccentric pericardial effusion after radiation therapy of left breast cancer. *AJR.* 1977;128:27-30.



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Bronchial Foreign Bodies Simulating Endobronchial Malignancy

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Reported are two cases of benign endobronchial lesions with granulomatous reactions that led to complete airway obstruction. Combined with a long history of cigarette smoking and the appearance of a hilar mass, these lesions appeared clinically to be bronchogenic carcinomas. Both cases went to thoracotomy, but in each case the requirement that malignant tissue be identified, allowed recognition of a foreign body in one case, and broncholith in the second, avoiding pneumonectomy in both cases.

Case 1

A 58-year-old African American male presented to the emergency room with a 12-hour history of increasing shortness of breath, left sided pleuritic chest pain, productive cough, subjective fever, and chills. He consumed 2 to 3 beers/day and had approximately a 50-pack year cigarette smoking history. The patient's temperature was 101.8°F. He was tachypnic, tachycardic, and hypertensive.

Physical examination was pertinent for decreased breath sounds over the left chest with bibasilar rales and egophony. White blood count was 23,100 with a left shift. Arterial blood gases on 2 L/min nasal cannula were pH 7.46, pCO_2 35.6, pO_2 62. Chest radiograph revealed calcified hilar and peribronchial lymph nodes, left lower lobe infiltrate/atelectasis, and left pleural effusion.

The day following admission, the leukocyte count decreased but the patient's oxygen requirement increased. In addition, there was worsening of the left lung infiltrate and collapse. Computerized tomography of chest showed right basilar, lingular and left upper lobe airspace disease representing atelectasis and/or pneumonia. There were calcified mediastinal and peribronchial nodes (Figure 1-A) and a small fluid collection in the lingula resembling an abscess. Fiberoptic bronchoscopy revealed a fungating mass completely occluding the lingular bronchus (Figure 1-B). Biopsy was performed. Also noted was marked compression of the left lower lobe bronchi.

Thoracentesis recovered bloody fluid which was an exudate. Gram stain showed gram positive diplococci but culture of the pleural fluid was negative. Sputum grew pneumococcus. The endobronchial biopsy showed extensive acute and chronic inflammation with squamous metaplasia, negative for malignancy.

Thoracotomy was recommended for possible malignancy. Prethoracotomy bronchoscopy revealed a small yellow tan calcified mass in the lingular bronchus which appeared to be calcified. The calcified mass was removed with forceps. Lingular segmentectomy was performed and frozen section failed to reveal malignancy. Pleural decortication was performed on the collapsed lower lobe. The postoperative course was uneventful and the patient was discharged to home. The post-operative chest roentgenogram showed blunting of left costophrenic angle but good expansion of left lung.

Case 2

A 69-year-old man with a 100 pack-year smoking history was referred to the pulmonary service for evaluation of an abnormal chest radiograph. He had a chronic cough productive of yellow sputum but denied hemoptysis, fever, chills or weight loss. Physical exam revealed rhonchi in the left upper lung field but was otherwise unremarkable. A complete blood count and blood chemistries were normal. Chest radiograph (Figure 2-A) revealed left hilar fullness with a left upper lobe perihilar infiltrate. Computerized tomography of the chest demonstrated a left hilar mass with a "postobstructive infiltrate." At fiberoptic bronchoscopy a fungating endobronchial mass was seen in the left upper lobe bronchus, with near total occlusion of the lumen. A moderate amount of purulent secretions emanated from the region. Bronchial brushing and

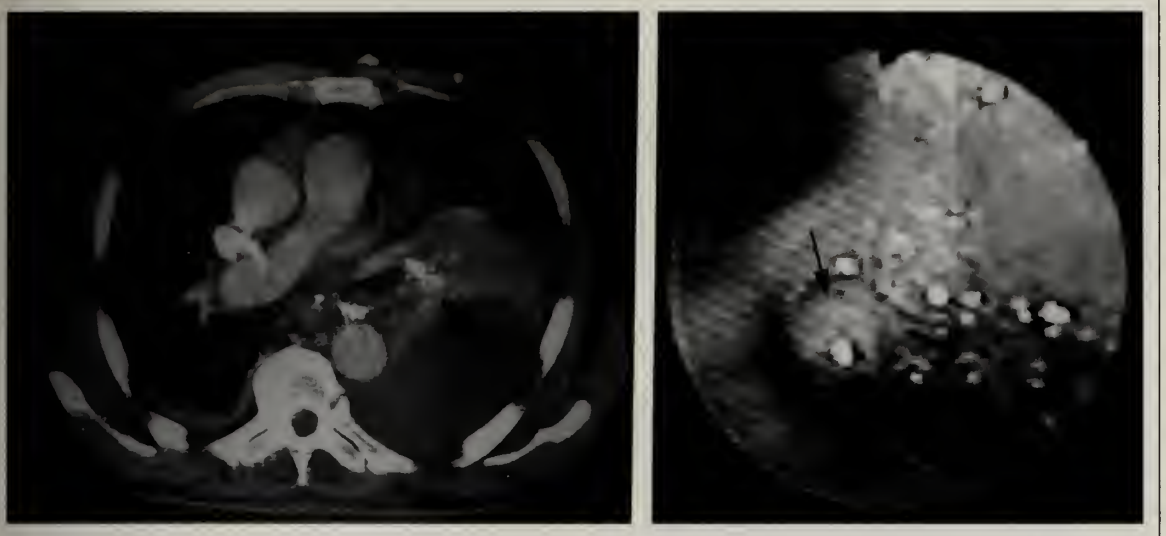


Figure 1 — A. Computerized tomography section through the proximal lingular airway. The airway is occluded by a lesion that appears to have a calcific mass in the center.
B. Photograph via fiberoptic bronchoscopy showing endobronchial mass (arrow) protruding from and obstructing the lingular orifice. Biopsy of this tissue was negative for malignancy (arrow).

washing revealed inflammatory changes but no malignant cells. Cultures of endobronchial secretions were negative.

The patient was taken to the operating room for left thoracotomy and lobectomy for presumed bronchogenic carcinoma. At thoracotomy, multiple bronchial and peribronchial biopsies failed to demonstrate a malignancy. A sterile fiberoptic bronchoscope was inserted through a bronchotomy into the left mainstem bronchus and in the midst of the previously observed fungating lesion. A yellowish foreign body was recovered by grasping it with the flexible biopsy forceps and removing the bronchoscope. The foreign body appeared to be a vertebral body with a dorsal spine (Figure 2-B), probably that of a fish. Stains of bronchial washings revealed gram positive branching hyphae reported as actinomycosis.

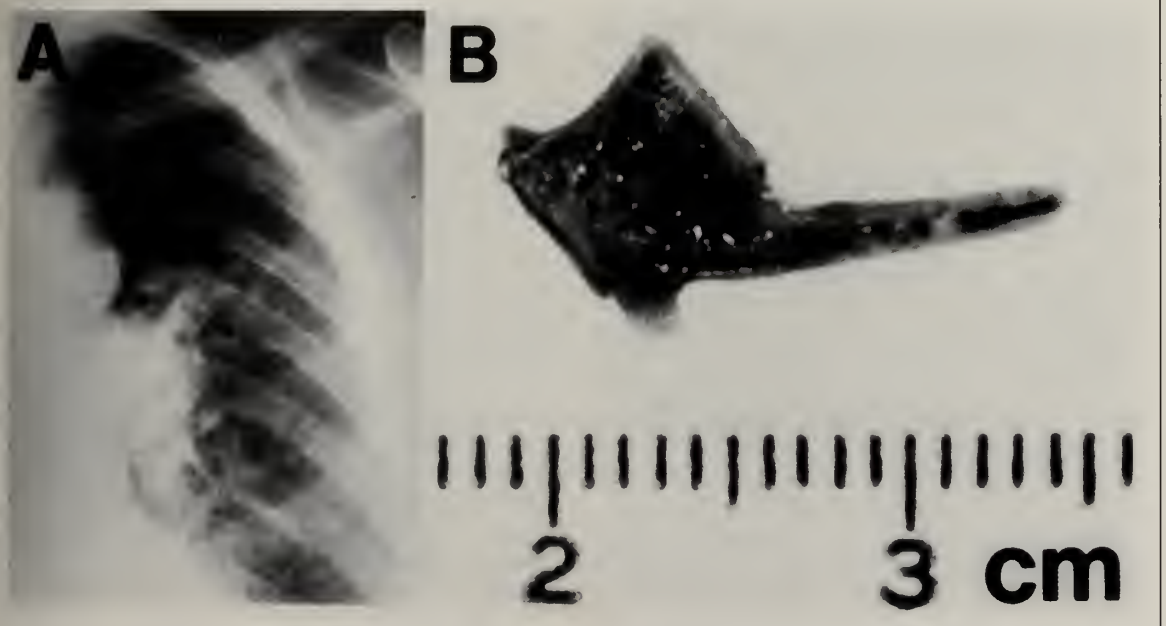


Figure 2 — A. Chest radiograph showing left hilar mass suspicious for malignancy.
B. Photograph of foreign body (fish spine) removed from bronchus intraoperatively using flexible forceps through a bronchoscope.

Postoperatively the patient recalled an episode of aspiration of a fish bone 16 years earlier. At that time a laryngoscopy and esophagoscopy failed to show a foreign body. Rigid bronchoscopy was not carried out at that time because of the patient's refusal.

Discussion

Atelectasis or infiltrate accompanied by the appearance of a hilar mass on chest roentgenogram, in a patient who has been a heavy smoker, is highly suggestive of a malignant endobronchial obstruction. When bronchoscopy confirms the presence of an endobronchial mass, the odds are overwhelming that bronchogenic carcinoma is the cause and that surgical removal of a part or all of the involved lung will be the most likely course of action leading to potential cure. Rarely, a benign process can simulate endobronchial malignancy. A persistent attitude, on the part of the treating physicians, requiring that tissue confirmation of malignancy be made prior to major surgical resection, may save the patient a more radical procedure such as pneumonectomy in the rare case where a benign lesion is the source of the obstruction. These two case reports illustrate unusual lesions which, up until the time of surgery, had every appearance of endobronchial malignancy.

Case one typifies broncholithiasis, a disorder characterized by bronchial inflammation or obstruction caused by a broncholith. A broncholith is a calcified lymph node or other calcified material within the bronchus. The definition has been expanded to include peribronchial calcified lymph nodes which distort the anatomy of the airway.[1] The important radiologic characteristic is calcification of an endobronchial or peribronchial lymph node. Plain chest radiograph, tomography, or computerized tomography can suggest a diagnosis of broncholithiasis.[2] Any disorder causing calcification of soft tissue or lymph node can lead to formation of a broncholith. Most frequently this occurs as a result of granulomatous infections such as tuberculosis or fungal disease. With obstruction of the bronchus, either by an endobronchial lesion or external bronchial compression, the resulted chronic inflammation may show cells with an atypical appearance. The patient in the present case had a fungating endobronchial lesion simulating bronchogenic carcinoma as a result of the chronic inflammatory reaction to a calcified lymph node which had eroded into the bronchus.

The majority of episodes of lung aspiration are symptomatic, although occasionally several years may lapse before the onset of symptoms.[3] Usually, delayed symptoms are from manifestation of airway obstruction: wheezing, atelectasis and infection. Radiographic signs include hyperinflation, atelectasis, infiltrate and in a minority of cases, visualization of a radiopaque foreign body.[2] There are case reports of bronchial foreign bodies simulating bronchogenic carcinoma, not infrequently detected at thoracotomy.[3] Cytologic samples in the second case suggested superimposed actinomycosis, although cultures failed to confirm this. Thoracic actinomycosis may occasionally simulate lung carcinoma and is sometimes diagnosed after lung resection. In addition, actinomycosis has been reported with a bronchial foreign body simulating an endobronchial malignancy.[4]

The foreign body in our patient remained in the bronchus for at least three years judging from previous chest roentgenograms. However, we cannot exclude its presence for 16 years dating to the episode of aspiration recalled by the patient.

The latency between the initial aspiration and the onset of symptoms as well as the infrequent radiologic identification of a radiopaque body make the diagnosis of foreign body aspiration difficult. A high index of suspicion was required in order to correctly diagnose foreign body granuloma endoscopically, thereby avoiding pneumonectomy. In the present case, absolutely no portion of the foreign body was identified during preoperative bronchoscopy. The dorsal spine of the vertebral body became visible at the center of the mass after manipulation and distortion of the lung at thoracotomy.

While such benign causes of endobronchial obstruction are relatively rare compared to the more ominous diagnosis of bronchogenic carcinoma, the recognition of the benign disease is extremely important to the occasional patient with this problem. If the lung distal to the obstruction is not grossly infected or destroyed, resection of the parenchyma can be avoided. In some cases, the endobronchial foreign body can be removed and the granulation tissue resected by rigid bronchoscopy or at thoracotomy by sleeve resection of the bronchus. Only a strong suspicion of foreign body granuloma, or the requirement that a malignant etiology of the lesion be identified prior to full lung resection, can expose these rare but significant cases of bronchial obstruction that might otherwise lead to unnecessary lung resection.

References

1. Arrigoni MG, Bernatz PE, Donoghue FE. Broncholithiasis. *J Thorac Cardiovasc Surg.* 1971;62:231-237.
2. Conces DJ, Tarver RD, Vix VA. Broncholithiasis: CT features in 15 patients. *Am J Radiology.* 1991;157:249-253.
3. Weiss E, Krusen FH. Foreign body in the lung for thirty-five years complicated by abscess and tumor formation. *JAMA.* 1922;78:506-507.
4. Weissberg D, Schwartz I. Foreign bodies in the tracheobronchial tree. *Chest.* 1987;91:730-733.
5. Nigam BK, Bronchial foreign body masquerading as a lung carcinoma. *Indian J Chest Dis Allied Sci.* 1990;32:43-47.
6. Umeki S, Nakajima M, Tsukiyama K, et al. Foreign body-induced bronchial actinomycosis with severe stenosis that must be distinguished from lung cancer. *Nippon Kyobu Shikkan Gakkai Zasshi.* 1990;28:481-486.

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Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal.* The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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Health Care for Kentucky's Uninsured Indigents: The Perspective of Providers in the Kentucky Physicians Care Program

Arch G. Mainous III, PhD; Charles H. Griffith III, MD, MSPH; L. Joyce McCown

The pressing issue of providing care for the uninsured indigent has been addressed in Kentucky by a unique private sector program that depends on physician donation of services. The Kentucky Physicians Care (KPC) program which provides health care to uninsured indigent patients in Kentucky was evaluated from the perspective of the participating physicians through in-depth interviews with 22 randomly selected physicians. The results of the interviews suggested that the KPC program is generally viewed by participating providers as a successful and personally rewarding enterprise. Suggestions for improving services included strategies to increase awareness of the program for both patients and providers. As state and federal policy continues to focus on the uninsured as a vulnerable population, integration of this private sector program into a partnership with the public sector may be a worthwhile strategy.

An estimated 40 million Americans have no health insurance.[1] Lack of health insurance has been shown to be related to a decreased likelihood of using ambulatory care,[2,3] obtaining preventive services,[4,5] and having a usual source of care.[6,7]

Individuals in Kentucky have attempted to address the problems of health care access for the uninsured with a relatively unique program coordinated through a private foundation, Health Kentucky, Inc (formerly known as the Kentucky Health Care Access Foundation, Inc). The foundation administers a statewide voluntary safety net which includes the Kentucky Physicians Care (KPC), a program organized by the Kentucky Medical Association. The KPC program is a referral system whereby indigent patients, below 100% of Federal Poverty income, who are ineligible for Medicaid or any other type of governmental medical program can be referred to participating Kentucky physicians. As of January 1995, more than 136,000 Kentuckians were certified eligible for the KPC program. The volunteer participating physicians are asked to see the patient at no charge for the first visit and to see them for needed subsequent visits based on the patient's ability to pay. The program strongly encourages continuity of care, but if the physician cannot provide ongoing free care to the patient the patient is referred back to the program for referral to another participating physician.

The purpose of this study was to evaluate the program from the perspective of the provider.

Fram the Departments of Family Practice (AGM, LJM) and Internal Medicine (CHG), University of Kentucky. Dr Mainaus is naw at the Department af Family Medicine, Medical University af Sauth Caralina.

The study was funded in part by a grant fram Health Kentucky, Inc and the Good Samaritan Faundatian, Inc.

Methods

In-depth interviews with a sample of 22 randomly selected physicians in the KPC program were conducted. All interviews were conducted using a semi-structured interview schedule. The interviews were conducted by phone at the convenience of the physician and required less than 15 minutes to complete. In-depth interviews were conducted to clarify and expand on issues related to the provision of care in the KPC program. The in-depth interviews were content analyzed with the recording of major themes and context.[8]

Results

Perceptions of KPC Patients

The specialties of the participating physicians varied from general practice to areas of specialty. Ninety-five percent of KPC patients are seen primarily in the office setting. According to the informants, the majority of KPC patients are seen for acute illnesses and routine exams, while about a third are seen for illness of a more chronic nature. The informants believed that the KPC patients sought care when medical attention was truly needed. Unanimously, the informants found no problem with KPC patients showing for appoint-

ments. However, the screening procedure of the KPC candidates was questioned by some physicians (10%) who believed some persons utilizing the program were not qualified recipients.

Most of the interviewed physicians find the KPC patient to be similar in nature to the Medicaid patient. Although the overwhelming majority of the providers believed most KPC patients were grateful for the care received, two providers feel that the KPC patient is not appropriately grateful and tends to expect that the care as well as ancillary services will be free.

Perceptions of Administration of the Program

Most participating physicians reported having no problem with the administration process of the program. Approximately one-third (32%) could not comment on the administrative process because it is handled by their office staff. The remaining 8% said that the KPC patient's knowledge of the procedures of the program is so poor that it creates more work for their staff.

About a third (32%) of the primary care providers found it difficult to refer patients due to a shortage of specialists participating in the program. This feeling was particularly acute in more rural areas. It was suggested that the program could be enhanced by providing a list of participating specialists to the participating physicians.

Perceptions of Importance of the Program

The majority (64%) of participating physicians feel that this is a much needed program which enables them to give back to the community. Many expressed personal satisfaction in helping to provide such a service. Other physicians claimed no direct benefit, but felt that providing free care is part of their social obligation as a physician.

Preventive Services in the KPC Program

When asked how they handle preventive services, the informants were grouped nearly equally into three primary strategies. One group reported that they send KPC patients to the health department, local hospital, or that the service is provided by traveling medical facilities once a month for a nominal fee. Another group reported that all preventive services were handled in their office, and a third group of providers reported that they do not provide these services or chose not to comment due to the small percentage of KPC patients in their practice. A small percentage of providers send patients back through the program with recommendation for testing.

Utility of Telephone Triaging with the KPC Population

Telephone triaging was not perceived to be useful with KPC patients by a substantial proportion of providers because most patients either need to be seen or they do not have access to phones. An alternative theme was forwarded by a smaller group of physicians who felt that telephone triage was useful or could be useful with the KPC patient in terms of placement with the correct physician, although it was stated that office staff tend to be non-committal and usually suggest that patients be seen. Nearly a third of the informants would not comment on triaging because it is handled primarily by office staff.

Suggestions for the Program

When asked about alternative ways to provide care about a fourth of the interviewed physicians reported being pleased with the program and no alternatives came to mind. Among those that did offer suggestions a common theme was to increase continuity of care, perhaps by opening an afternoon clinic staffed by volunteer physicians. Other suggestions included: (1) Creation of a national health care plan; (2) Creation of a program similar to Medicaid; (3) Send uninsured indigents to the local Health Department; (4) Send uninsured indigents to the University of Kentucky or University of Louisville; and (5) Generate more tax dollars and use those funds to pay physicians to promote care for indigents.

Specific comments about improving the program included improving pharmacy services to KPC patients by increasing pharmacy and pharmaceutical company participation. Moreover, many patients do not have transportation and need to travel to other cities to locate participating pharmacies. It was also stated that there is a need for feedback from pharmacies regarding individuals who participate in the program.

Other comments included: (1) A need for more networking among participating physicians enabling them to know what medical areas need attention and if any physicians are overburdened with KPC patients; (2) A need for a quarterly letter sent out to physicians on the progress of the program; (3) A need for physicians and recipients to be better informed on the benefits and procedures of the KPC program since the program may actually be underutilized due to lack of knowledge; and (4) The patient participant screening process needs to be reviewed to ensure qualified patients.

Discussion

The Kentucky Physicians Care program represents a unique attempt to overcome the problem of access to medical care for the indigent and uninsured through the altruism and voluntary participation of providers. We attempted to evaluate the relative success of this program from the provider's point of view. From the provider's point of view the program appears to generally be a success. The patients seen are viewed as in need of medical attention, keep their appointments, and are appreciative of the care. Many of the patient problems (68%) are acute problems, with most care provided in the provider's office rather than in an emergency room (the only other outlet for many of these patients). Most KPC providers found the program personally fulfilling or a part of their social obligation as physicians.

The KPC program appears to be effective in overcoming the problem of access to care for the uninsured indigent, in a way that is fulfilling to providers. However, challenges for the program noted by the providers include the difficulty of identifying participating specialists and pharmacies for those patients identified as needing a referral or needing medications. Additional challenges for providers is furnishing preventive services for the uninsured, since there is often no outlet or funding source to pay for ancillary tests (ie, mammography, cholesterol screening, etc).

Phone triage is also a challenge for this population of patients who many times have no phone. The primary suggestions of the providers to improve the program involve better communication between and information about participating providers, specialists and pharmacies, as well as better communication of information for patients who may qualify but be unaware of the program.

There are several limitations to this study that should be noted. First, the generalizability of this information to other states and programs for the uninsured may be limited. However, this is a unique program that has been successful in Kentucky and may actually be valuable as a model for other states. Second, the data are based on the perspectives of community practitioners whose knowledge of the program may be limited. It was suggested by the informants that more education of the medical community about the program would be helpful. The perspective of practitioners actually providing care in a program based on physician donation of services would seem however to be invaluable data.

In summary, the KPC program is generally viewed by participating providers as a successful and personally rewarding enterprise. Creative solutions like the KPC program to pressing health care delivery issues such as access to care for the medically uninsured should be applauded. Further innovations and improvements to programs like this will help to provide a full range of health care to the medically uninsured.

References

1. Employee Benefit Research Institute Special Report SR-28, issue brief number 158, February 1995.
2. Stoddard JJ, St Peter RF, Newacheck PW. Health insurance status and ambulatory care for children. *N Engl J Med.* 1994;330:1421-1425.
3. Rowland D, Lyons B. Triple jeopardy: rural poor, and uninsured. *Health Services Res.* 1989;23:975-1004.
4. Bindman AB, Grumbach K, Osmond D, Vranizan K, Stewart AL. Primary care and receipt of preventive services. *J Gen Intern Med.* 1996;11:269-276.
5. Health insurance coverage and receipt of preventive health services — United States, 1993. *MMWR Morbidity and Mortality Weekly Report.* 1995;44:219-225.
6. Needleman J, Arnold J, Sheila J, Lewin LS. The Health Care Financing System and the Uninsured. Washington, DC: Lewin/ICF, 1990.
7. Shoen C, Lyons B, Rowland D, Davis K, Puleo E. Insurance matters for low-income adults: results from a five-state survey. *Health Affairs.* 1997;16:163-171.
8. Weber RP. Basic Content Analysis. Beverly Hills, CA: Sage, 1985.

"Fear and Loathing at Fifty"

Every eight seconds, another Boomer Baby is turning 50 years old. My turn came round last year, attended by the customary well-wishers at my birthday party inflicting upon me the requisite assortment of laxatives, hemorrhoidal preparations, stool softeners, adult diapers, and impotence aids. Truth be told, some of these have actually turned out to be quite useful. Nonetheless, subsequent moments of fretful reflection upon my first half century of life allowed me several profound insights which I will share with you. Indeed, I now envision myself much in the manner of an ancient Colossus astride the Harbor of Time, one foot firmly planted on the shore's edge of the Twentieth Century, the other foot tentatively seeking out firm ground in the coming century, the icy winds of change blowing fiercely between my fluttering britches.

Consider that in the year I was born, Harry Truman was President, Uncle Joe Stalin held firm sway over the Evil Empire, Mahatma Gandhi was spinning his wheels and Israel was not yet a state. Computers, such as they were, required the size of a warehouse, space travel was science fiction, transistors were non-existent. Orville Wright (yes, *the* Orville Wright) was alive as was Al Capone (yes, *the* Al Capone). Jackie Robinson just broke the color barrier, no one yet broke the sound barrier and Babe Ruth was still swinging. Polio vaccines, open heart surgery, organ transplantation, and the DNA code all awaited discovery. Fifty years later, I can't surf the Internet without falling off nor program my VCR.

So here I humbly offer some observations that may aid others skirting middle-age to determine if the clammy fingers of 50 are clutching at the hems of their white coats. To wit, you may find yourself turning 50 if:

- Everything hurts.
- You're stiff in all the wrong places.
- You're thinking you never looked that young when you were a medical student.
- You ask your medical students to find laboratory data for you on the computer.
- You are grateful when people you know and work with daily wear their name tags.
- You mill about the parking lot every night in bewilderment trying to remember where you parked your car.
- You wait for the elevator to go up or go down one flight of stairs.
- Your locker becomes progressively crammed with aspirins, ibuprofen, and antacids.
- You shake the hand of a regular patient of yours in the office and tell them how nice it is to meet them.
- You see a patient in follow up in your office a week later and, for the life of you, can't remember what operation you did on them.
- Your nurse has to give you a list of appointments and instructions each morning, lest you wander aimlessly down long hallways lost and hungry.
- More and more, journal articles seem to be reinventing the wheel.
- Your scrub clothes seem to be shrinking.
- You perform procedures with swiftness and efficiency not so much because of your experience but because you have to go to the bathroom.
- You forget to zip up.
- Worse, you forget to zip down.
- You become increasingly preoccupied with your bowel movements.
- You find yourself wearing magnifying loops for every surgical procedure.
- You play music in the operating room of bands that were popular before your resident was ever born.
- Worse, you play music in the operating room of bands, most of whose members were *dead* before your resident was ever born.
- You catch yourself saying, "in my day when I was a resident . . ." or, "I remember when . . ."
- Your patients ask if those nice pictures of the wife and kids on your desk are those of your daughter and grandchildren.
- Finally, you find yourself sitting in the emergency room at 2:30 a.m. with the discomfiting and unwelcome thought seeping into your foggy brainpan, "What in the blazes am I doing here and why? . . ."

Well, as my spiritual guru from the eighties, Ronald Reagan, once said, (to paraphrase), "I just reached 50—but remember, folks, that's only 10 celsius."

Jaroslav P. Stulc, MD



I Am 75 Years Old. I Am Medicine's Best Friend. Who Am I?

My birth occurred in 1923 in Crab Orchard, Kentucky, where thousands of Kentuckians had migrated starting back in 1775. It was an inauspicious event, barely noticed, and there was no TV coverage. Even though the bells did not chime and the air waves did not hum, my effect on the field of medicine would grow and grow and grow. Without the help of Dr Arthur T. McCormack, my birth probably would have been greatly delayed, but I would have been born sometime. Because, you see, I was needed. The medical profession was having a tough time in those days and something needed to be done to counter the adverse publicity that was impugning the image of medicine. (*Can you guess who I am?*)

I became a twinkle in the eye of Dr McCormack, who was Secretary of the Kentucky State Medical Association, after he learned from a colleague, Dr Holman Taylor, MD, Secretary of the Texas State Medical Association, about the organized efforts of "Doctors' Wives" in Texas to help protect their husbands' integrity amid the recent invasion of "Medical Charlatans" in their state. Dr McCormack was inspired by what was happening in Texas and felt the same was needed in Kentucky. The prospect for my birth was established when The Kentucky State Medical Association Council approved Dr McCormack's recommendation to help organize the "Doctors' Wives" at their annual meeting in 1921. In May 1922, Dr McCormack was further inspired when he heard Mrs S.C. Red, the first President of the Texas Auxiliary, speak at the AMA House of Delegates meeting where she challenged the doctors in attendance to help her organize a national organization for "Doctors' Wives." Dr McCormack was impressed with Mrs Red's presentation and was confident his dear Kentucky would be receptive to this idea. In the fall of 1922, at the state medical association meeting in Paducah, he appointed a chairman of a committee to consider my birth; however, after much discussion, there was no one present who felt they could undertake such a responsibility at that time. The seed had been planted, however, and with time to grow amid much consideration and discussion about the endeavor, the following year I was born. (*Enough hints yet?*)

My name has changed over the years; however, my dedication has never wavered. Oh yes, my face has changed also. I am no longer only an organization of "wives" because now it

appears that about 40% of my future make up will be males. My commitment has been most admirable, if I do say so myself. As early as 1930 I had initiated a weekly radio program called "Radio Waves," to discuss good health practices. Over the years I have publicized multiple public health hazards, fought for better access to health care, distributed information about teen pregnancy, assisted in public vaccination and school health programs, raised funds for medical research and education, and been active in the political arena. So you see, I've had a long and productive life, and I'm still growing. Some goals I hope to accomplish this year are to reach approximately 100,000 teachers and school staff throughout the public school system with breast cancer awareness information and a reminder to get mammograms; to reach approximately 200,000 school children, kindergarten through 3rd grade, throughout the state with anti-violence materials teaching children how to handle conflict without violence; to get more people trained and expand the SMART (Students Made Aware Reject Tobacco) program and thereby teach as many children as possible about making responsible choices and the hazards of smoking; to endow scholarship funds at both the UK and UL medical schools; become better educated in how to participate effectively in the legislative process; and last but not least, I want to have a presence in more counties and become better organized. Whew! Makes an older one like myself almost gasp for breath, but it can be done if all the parts work well together. It almost makes me feel born again to be able to use the lessons of the past to create a brighter future.

Who am I? I am the KMA Alliance! The medical profession's best friend.

I celebrated my 75th birthday at the spring convention in Madisonville in April. Dr Trover, who founded the Trover Clinic that changed the face of medicine in that part of Western Kentucky, was one of the special guests present for the celebration and was the guest speaker. The huge birthday cake was enjoyed by all. Hopkins County sure knows how to throw a party!

We celebrate this year with an absolutely great board! They are as follows:

Executive Committee

President-Elect	Carolyn Daley (G.I.)	Hazard
Vice-President — AMA/ERF	Vicky Borders (Jack)	Ashland
Vice-President — Health Promotion	Audrey Carter (Keith)	Louisville
Vice-President — Legislation	Angie DeWeese (Bob)	Louisville
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Secretary	Nancy Bunnell (Thomas)	Edgewood
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AMA-ERF	Vicky Borders (Jack)	Ashland
Archives	Nancy Swikert, MD (Donald)	Florence
Bluegrass News Editor	Mary Evans (Carl)	Lexington
Bylaws	Debbie Bruenderman (David)	Louisville
Doctor's Day	Marla Vieillard (Louis)	Russell
Finance	Mary Anne Chapman (Scott)	Robards
Health Promotion	Audrey Carter (Keith)	Louisville
Invocation	Sharon Kelley (Steve)	Wilmore
Legislative Affairs	Angie DeWeese (Bob)	Louisville
Phone Tree	Joan Slattery Burke (Frank)	Lexington
Medical Heritage	Jan Crase (Jim)	Somerset
Membership Development	Cathy Kavanagh (Kevin)	Somerset
Members-at-Large	Ann Wheeler (William B.)	Lexington
Nominating	Aroona Dave (Uday)	Madisonville
Public Relations	Dee Pierce (Mark)	Paducah
Planning	Carolyn Daley (G.I.)	Hazard

Special Committee Chairmen

Annual Convention	Joyce Clark (Danny)	Somerset
Annual Reports	Maggie Becker (Philip)	Villa Hills

Special Committee Chairmen (continued)

Day at the Capitol	Angie DeWeese (Bob)	Louisville
Fall Board	Donna Kruger (Willem)	Louisville
Volunteer Hours	Terri Hudepohl (Robert)	Lakeside Park
Winter Board	Cheryl VanDaalen (James)	Louisville

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Boyd	Becky Staten (Ronald)	Ashland
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Jefferson	Dianne Cox (Warren)	Louisville
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McCracken	Holly Locken (Peter)	Paducah
Northern Kentucky	Connie Combs (James)	Burlington
Perry	to be announced	
Pulaski	Cheri Gomez (Ed)	Somerset
	Melissa Huffman (Mark)	Somerset
Warren	Tammy Bergamini (David)	Bowling Green

A very special recognition goes to each of these board members for their commitment to the Alliance during this *diamond anniversary* year and particularly a special thanks to you physicians who recognize the importance of the role of the Alliance and are so supportive of your spouses participation in this organization. The Alliance has a very rich history in both this Commonwealth and the Nation and is truly Medicine's best friend.

Jan Crase
KMAA President

Special thanks to Gloria Griffin for her 75th Anniversary research & information.

Board of Trustees Spring Board Meeting





Top: Secretary-Treasurer William P. Vonder-Haar, MD, is pictured at the podium. L to R are Vice Board Chair Donald R. Neel, MD; Vice President Harry W. Carloss, MD; President C. Kenneth Peters, MD; Board Chair J. Gregory Cooper, MD; and President-Elect Donald R. Stephens, MD. Bottom: Three KMA Past Presidents studied the Board reports. L to R are AMA Delegate and State Legislative Activities Chair Wally O. Montgomery, MD; AMA Senior Delegate and National Legislative Activities Chair Donald C. Barton, MD; and Alternate AMA Delegate and Public Education Committee Chair Preston P. Nunnelley, MD.

The KMA Board of Trustees met in regular session on April 8-9, 1998, at the KMA Building in Louisville. Board members heard reports from the President; Secretary-Treasurer; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Senior Delegate to the AMA; Chair, Kentucky Medical Insurance Company Board of Directors; President, KMA Alliance; and the Commissioner, Department for Public Health.

The Board adopted the budget for fiscal year 1998-99. In further action, the Board approved the nominees for reelection to the KMIC Board of Directors; selected nominees to the Breast Cancer Advisory Committee and the Breast Cancer Task Force; and reappointed the KMA/KMIC Board Joint Advisory Committee.

The Board adopted the recommendation of the Committee on Insurance and Prepayment Plans to collect information from members on the shifting of administrative burdens and costs by insurance companies to physicians. The Board also approved a survey of International Medical Graduates in Kentucky to determine unmet needs. In further action, the Board authorized KMA to allow credit card payments for dues and other KMA resources.

Additional reports were given by the Committee on Medicaid Managed Care, the Committee on National Legislative Activities, the Committee on State Legislative Activities, the Public Education Committee, and the Committee on Child and School Health.

The Board also heard information on HCFA Evaluation and Management Guidelines, web page development status, Fraud and Abuse Seminars, and Regional Trustee District meetings.

It was noted that the theme for the 1998 Annual Meeting is "The Team Approach to Healthcare: The Physician's Role," and that Nancy Dickey, MD, AMA President Elect, has been invited to attend dinner with the Board on Sunday evening and to address the House of Delegates on Monday.

The KMA Board of Trustees will hold its next regular meeting on August 5-6, 1998, at the KMA Building.

PEOPLE

Arnold M. Belker, MD, Louisville, recently was honored to present the inaugural Quinby Lecture on Male Reproduction at Harvard University. Dr Belker actually presented two lectures—one entitled "Sperm Retrieval Techniques for IVF/ICSI," at Massachusetts General Hospital, and "Reproductive Microsurgery for the Urologist," at Brigham and Women's Hospital.



Doctor Belker has achieved a national and international reputation as an outstanding microsurgeon and one of the leaders in the field of andrology and male reproduction. He has served as President of the Kentucky Urological Association, the American Society of Andrology, the Society of Reproductive Surgeons, and the Society for the Study of Male Reproduction. He has also been the President of the University of Louisville Medical School Board of Governors.

Richard J. Glassock, MD, Lexington, has been named a Master of the American College of Physicians. The College conferred mastership, its highest level of membership, upon 39 College fellows in an April convocation ceremony at its 79th Annual Session.

According to ACP bylaws, masters are elected "for their personal character, positions of honor or influence, contributions toward furthering the purposes of the College, and/or eminence in practice or in medical research." The American College of Physicians is the nation's largest medical specialty organization.

Scott B. Scutchfield, MD, Danville, has been named chairman of the Board of Councilors of the American Academy of Orthopaedic Surgeons. He has served as Kentucky's representative on the board since 1993.

Dr Scutchfield is a member of the board of directors of the American Academy of Orthopaedic Surgeons and is the regional representative for the Orthopaedic Research and Education Foundation. He has been chairman of the Kentucky Orthopaedic Political Action Committee since 1994 and is on the executive committee of the Kentucky Orthopaedic Association.

Dr Scutchfield is in private practice and serves on the staff of Ephraim McDowell Regional Medical Center in Danville. He is an assistant clinical professor, department of orthopaedic surgery, University of Kentucky College of Medicine.

UPDATES

Viagra Receives FDA Approval

Pfizer Inc has announced FDA approval of the oral therapy Viagra (sildenafil citrate) for the treatment of erectile dysfunction. According to Pfizer, Viagra is effective in most men with erectile dysfunction (ED) which is associated with a broad range of physical or psychological medical conditions.

Discovered and developed by Pfizer, Viagra is the first in a new class of medications known as phosphodiesterase type 5 inhibitors. Pfizer states that in clinical trials, which included men with a broad range of conditions associated with ED including high blood pressure, high cholesterol levels, diabetes, and prostate surgery, Viagra was shown to be effective in approximately 7 out of 10 men overall. Common side effects noted in the report were headache, facial flushing, and indigestion. Pfizer cautions that Viagra should not be used by patients taking nitrates in any form, including the heart medicine, nitroglycerin.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Joseph B Touma MD — OTO
1616 13th Avenue Ste 100, Huntington 25701-1692
1963, Damacus U, Syria

Christian

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1992, U of Louisville

Fayette

Tony W Dotson DO — OBG
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1997, Chicago Homeopathic

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1989, King Edward Med, Pakistan

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1985, U of Louisville

Jefferson

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1981, Ohio State, Columbus

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1992, U of S California

Andrew M Donovan MD — PD
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1994, U of Louisville

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Pike

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IN TRAINING

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Brent Allen Madison MD — PD
Matthew Lane Offutt MD — PD
Sujittra Tongprasert MD — AN
Robert Joseph Wasson MD — EM

DEATHS

James B. Jones, Jr, MD
Lexington
1922-1998

James B. Jones, Jr, MD, a retired OB/GYN, died February 26, 1998. Dr Jones graduated from the University of Tennessee College of Medicine in 1949 and was a life member of KMA.

Russell S. Long, MD
Frankfort
1923-1998

Russell S. Long, MD, a retired general practitioner, died March 16, 1998. A 1956 graduate of the University of Louisville School of Medicine, Dr Long was a life member of KMA.

Walter M. Shelly, MD
Hazard
1933-1998

Walter M. Shelly, MD, a thoracic surgeon, died March 20, 1998. A 1959 graduate of Jefferson Medical College of Thomas Jefferson, Dr Shelly was an active member of KMA.

E. Philip Crawford, MD
Lexington
1931-1998

E. Philip Crawford, MD, a retired anesthesiologist, died April 1, 1998. A 1955 graduate of the University of Louisville School of Medicine, Dr Crawford was a life member of KMA.

James S. Golden, MD
Pineville
1922-1998

James S. Golden, MD, a retired general practitioner, died April 25, 1998. Dr Golden was a 1948 graduate of the University of Virginia School of Medicine. He was an artist, well-known for the figurines he made, and his works were featured in *National Geographic World* magazine and other mediums. Dr Golden was a life member of KMA.

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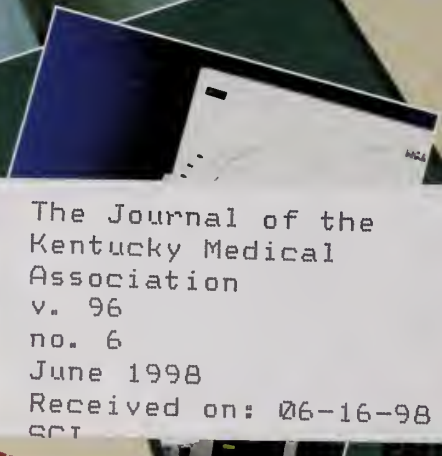
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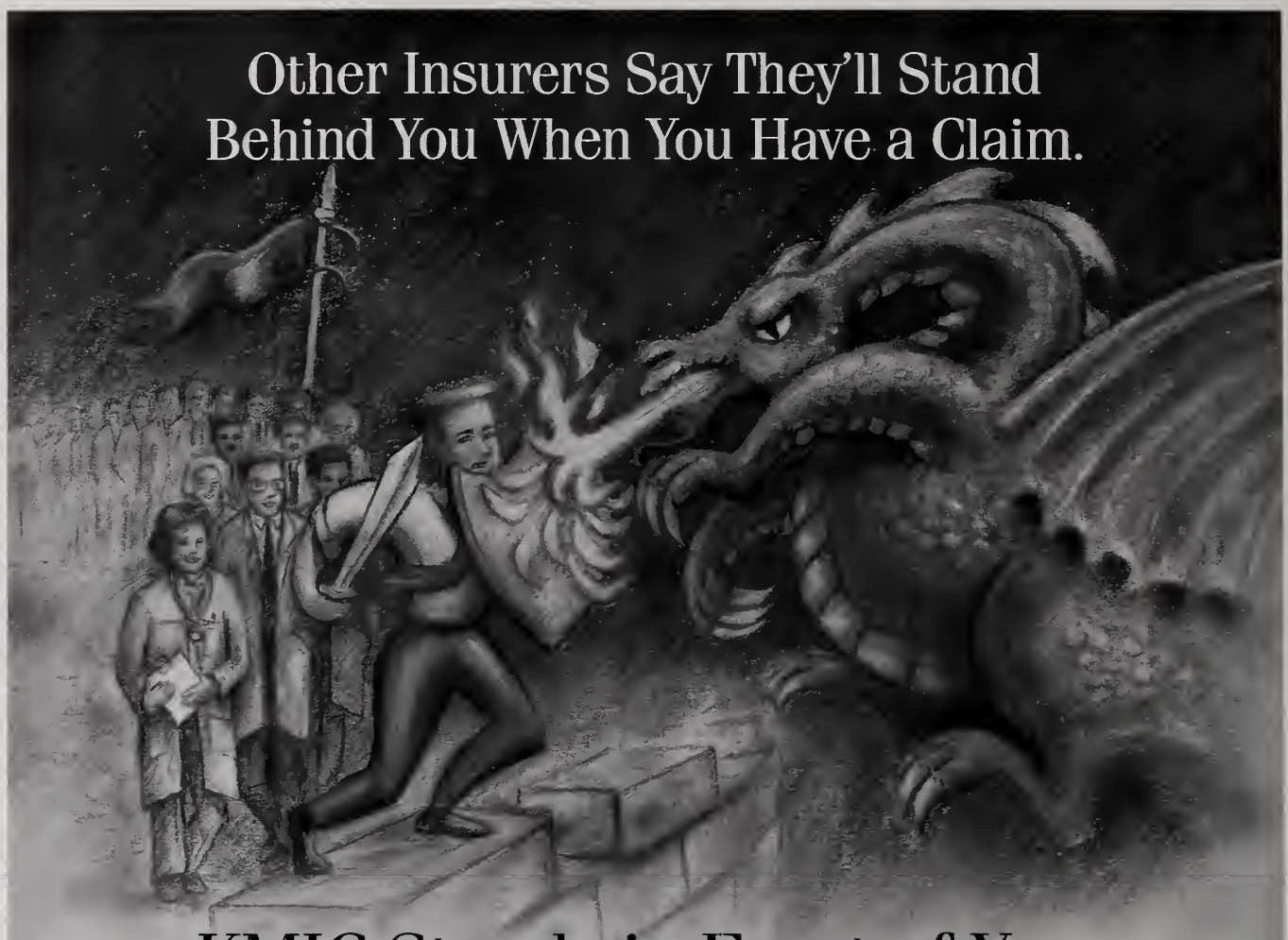
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COVER STORY	Keys to the City of Louisville—Your Host for the 1998 KMA Annual Meeting	254
SCIENTIFIC	Acute Pulmonary Histoplasmosis: Progressive Pneumonia Resulting from High Inoculum Exposure *Lee Tolar Meals, MD; W. Paul McKinney, MD*	258
	Upper Airway Resistance Syndrome *Nuzhat Hasan, MD; Eugene C. Fletcher, MD*	261
EDITORIAL	Provider? — Not Me! *Kimberly A. Alumbaugh, MD*	269
ASSOCIATION	*Monitoring Medicine*	251
	AMA Elects Three Kentucky Leaders	250
	News	274
ANNUAL MEETING	Nancy W. Dickey, MD, AMA President, Keynote Speaker	273
DEPARTMENTS	President's Page	249
	Advertisers' Guide	278
	Alliance Page	271
	Classifieds	277
	Information for Authors	264
	Letter to the Editor	265



COVER:
Join us in Louisville, Manday thraugh Wednesday, September 21-23, far the 1998 KMA Annual Meeting. See page 254 far a short, infarmative article on hatel and parking accommodatians, as well as a "key" to this progressive city.

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Are We Victims or Victors?



Donald C. Barton, MD

Physicians are beset politically, professionally, and economically by a variety of ills generated outside of the House of Medicine. Individually, we each come to terms with our own frustrations, whether we make peace with them or suppress them. We can let ourselves be victimized by these forces, or we can take personal and professional responsibility for these circumstances and work to change them.

We all want value in return for our professional, personal, or economic involvement. Conversely, we can't honestly expect accomplishment or fulfillment unless we expend involvement. If we don't become involved — take an active role in the strongest forces available to secure and improve our professional position — and then whine or rage over our conditions, we have chosen to become victims.

Collectively, some physicians have elected to take responsibility for our profession and join the AMA. Like all physicians, and humans, I want things "fixed" right now. However, we're all intelligent enough to know that the security of our profession does not rest on "winning" or "losing," but rather on the degree of success we achieve in any situation. Obviously, many of the problems that medicine faces now, and continuously, are political, so the only answers are political solutions.

Let's take a look at a few recent achievements by the "nonvictim" AMA.

Early in the evolution of managed care, physicians identified inappropriate or even harmful aspects of administrative provisions that conflicted with the practice of medicine. These included "gag" clauses, access to emergency services, access to specialists, point-of-service options, the legal responsibility of managed care "managers" in medical decision making, and the disclosure of information to patients on the operation of managed care plans. Through persistence and effective effort, the work of the AMA and its nonvictim members has resulted in some high-profile legislative support for these concerns. The administration has recently offered its Consumer Bill of Rights and Responsibilities, and there are bills in both houses of the US Congress — HR 1415 and S 644 — that contain most of these issues of concern.

Evolving changes to the Evaluation and Management codes for Medicare have drawn the fearful focus of all practitioners. In these pages you have already heard of the work of the AMA to revise these codes. More recently, a special meeting was convened by the AMA on April 27 with representatives of the medical federation from all over the country and officials of the Health Care Financing Administration to address these issues. As a result of these concerns, HCFA pledged to work with the AMA to improve the E & M guidelines, to conduct pilot tests of revised guides, and to undertake a program to educate physicians and carriers in the use of the revised guides. Another outcome of this meeting was that HCFA agreed to focus on the importance of documentation for patient care rather than financial accountability. Until this process is completed, carriers will be instructed to use the '94 or the new '97 guides for reviewing claims, using whichever version favors the physician, and the new guidelines will *not* become mandatory July 1, as originally proposed.

In a related area, the AMA's work on Fraud and Abuse provisions for Medicare has resulted in a commitment from HCFA to pursue only those cases that show fraudulent intent. HCFA has agreed to look only for patterns of true fraud and abuse, and not to pursue instances of honest mistakes.

At the state level, our involved physician peers have had a measure of success over the influence of state legislation. You will already have received a report on the 1998 session of the Kentucky General Assembly detailing this very effective work, so I won't repeat it here.

We've all heard the old adage that we have the type of laws and the kinds of politicians that we want, because they are both what we have chosen, or, we have allowed them to result. The same adage applies to the influences on our profession. If we wish to practice medicine as we know best, then we're going to have to work to make it happen. In my mind, the most direct and effective way to do that is to *join the AMA* and become active in all of our medical organizations. As a profession, we have probably always been intolerant of imposed authority, particularly when it affects the way we practice our science. We don't really need that authority, and we certainly don't want it. The only way we can confront that type of authority is to take responsibility for our own circumstances and become involved to change them.

Donald C. Barton, MD
Senior AMA Delegate

AMA Elects Three Kentucky Leaders

Ardis D. Hoven, MD, William B. Monnig, MD, and Bruce A. Scott, MD, were all honored by their colleagues at the AMA Annual Meeting, June 14-18, in Chicago. Hoven, Monnig, and Scott were elected to three prestigious leadership positions within the federation of medicine.



Ardis D. Hoven, MD

Ardis D. Hoven, MD, Lexington, KMA's first woman president, was elected to the AMA Council on Medical Service. Dr Hoven, a practicing infectious disease specialist at the Lexington Clinic, is a member of the Practicing Physician Advisory Committee to the Health Care Financing Administration. Originally elected to AMA Alternate Delegate, she presently serves as Delegate to the AMA. Hoven, a member of the AMA Group Practice Advisory Council, is active in women-in-medicine issues at the national, state, and local levels.



William B. Monnig, MD

William B. Monnig, MD, former three term Chair of the KMA Board of Trustees, was reelected as Secretary of the AMA Organized Medical Staff Section. Monnig was Founder and President of the OMSS in Kentucky. Monnig has served as a Member-At-Large of the AMA OMSS Governing Council, and remains active on the medical staffs of the hospitals where he practices urology in Northern Kentucky. William B. Monnig, a Past President of KMA, presently serves on the KMA Board as Alternate Delegate to AMA and is the 1998 Chair of KEMPAC.



Bruce A. Scott, MD

Bruce A. Scott, MD, a Louisville otolaryngologist, was elected to the Young Physician position on the AMA Board of Trustees. Dr Scott presently serves on the Governing Council of the AMA Young Physician Section and is that Section's Delegate to the AMA House. He served as Chair of the AMA Resident Physicians Section. He has served as a member of the Board of Governors, American Academy of Otolaryngology Head and Neck Surgery since 1994 and is an active member of KMA's Young Physician Section steering committee.

Other members of Kentucky's AMA Delegation include Senior Delegate Donald C. Barton, MD, Corbin; Wally O. Montgomery, MD, Paducah; Robert R. Goodin, MD, Louisville; Donald J. Swikert, MD, Florence, all Delegates. Alternate Delegates include Bob M. DeWeese, MD, Louisville; J. Gregory Cooper, MD, Cynthiana; Preston P. Nunnelley, MD, Lexington; and Baretta R. Casey, MD, Pikeville. Student and Resident leadership, along with Kentucky's OMSS delegation and other KMA officials and staff, also attended.

MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

HB 115 Being Implemented by KY Department for Public Health

Drug Control Branch Moves to Implement Electronic Tracking of Controlled Substances

Last year Attorney General Ben Chandler formed the Prescription Drug Abuse Task Force composed of physicians, representatives of the Kentucky Medical Association, the Kentucky Board of Medical Licensure, legislators, law enforcement personnel, and other concerned persons. This group developed proposed legislation to deal with the abuse of prescription drugs that became HB 115, which was passed by the 1998 General Assembly. The law will affect Kentucky's practicing physicians in the following ways:

- It protects physicians against prescription forgery by requiring that prescriptions for controlled substance be written on security prescription blanks that meet state requirements.
- It offers increased protection to physicians by creating new felony crimes for theft of prescription blanks, trafficking in prescription blanks, and illegal possession of prescription drugs or prescription blanks.
- It authorizes the reporting of all controlled substance prescriptions to a high security central data bank (KASPER) operated under strict access rules by the Drug Control Branch in the Department for Public Health.

The Kentucky All Schedule Prescription Electronic Reporting (KASPER) system is the centerpiece of HB 115. It will allow practitioners to obtain information regarding the controlled substance prescriptions received by a patient. The Department for Public Health believes this will free physicians to prescribe adequate quantities of controlled substances for legitimate medical needs by ascertaining that patients are not merely drug seekers who are manipulating multiple physicians.

Systems similar to KASPER have been operating successfully in other states for several years. One of the unique features of Kentucky's system is that dispensing physicians and mail-order pharmacies are included in the reporting requirement. Another is the protection for physicians by the requirement that the patient's diagnosis and the physician's specialty be considered in any investigation.

KASPER is expected to be operational in early 1999. More will be available in the coming months. If you have questions of general interest that could be addressed in future articles, please call Drug Control at (502) 564-7985.

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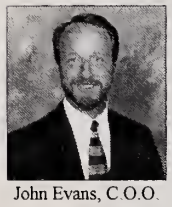
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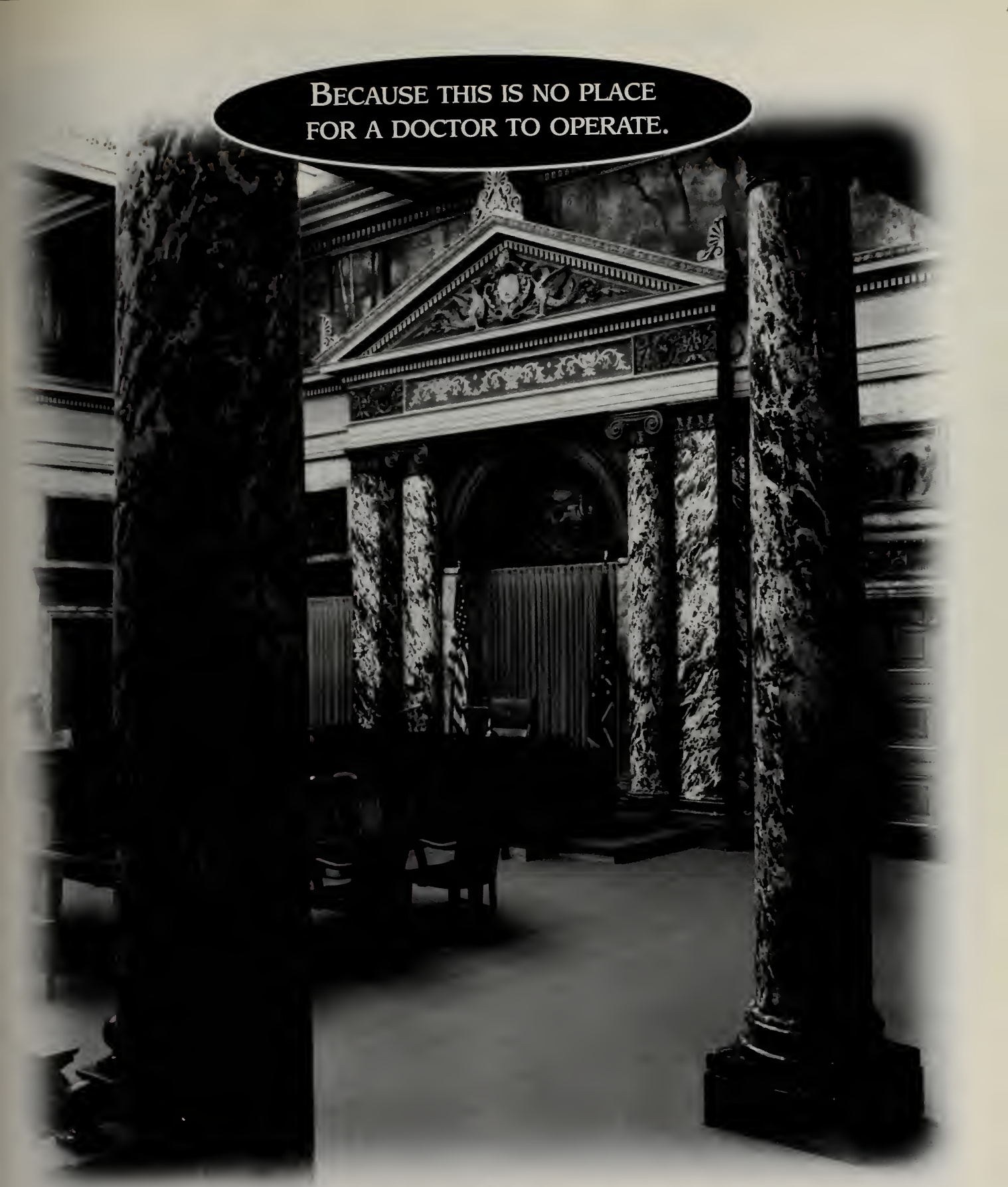
John Evans is a successful and accomplished medical professional with progressive experience in leading all areas of business planning, daily operations, financial reporting, and company growth. Complementing his professional career is a master of business administration (M.B.A.) earned from Vanderbilt University and a bachelor of science (B.S.) in business administration earned from the University of Illinois.

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More than 20 eminent out-of-state guest speakers and leading Kentucky physicians will provide programs offering many hours of continuing medical education during the Kentucky Medical Association's Annual Meeting, September 21-23, in Louisville. The scientific sessions and specialty society programs will update physicians on the many controversial and challenging issues of these times. With the many diverse topics, the meeting is certain to be of interest to every physician.

Hotel & Convention Center

KMA will return to the Hyatt Regency Hotel and Commonwealth Convention Center in downtown Louisville for this 148th Annual Meeting.

The Hyatt Regency Louisville, located at 320 West Jefferson, is a luxurious 20-story atrium hotel overlooking the Ohio River in the heart of Louisville's business and entertainment district. The Hyatt features The Trellis, a full-service restaurant located on the first level, and The Spire, an elegant revolving rooftop restaurant that offers a delicious lunch and dinner menu and a breathtaking view of the Louisville skyline. All business meetings and functions will be held in the Hyatt.

It is important that you make your room reservations as soon as possible for this year's meeting by calling the Hyatt—502.587.3434. ***Please be sure and indicate that you are attending the KMA meeting in order to receive the special convention rate of*** Single—$93 or Double—$104.

The Commonwealth Convention Center, located at 221 Fourth Avenue, will host KMA's General Sessions, specialty group meetings, and exhibit hall. The main registration desk will be located in the Convention Center. The Commonwealth Convention Center is one of the most functionally designed facilities of its kind with versatile lighting, computer climate control, and a sophisticated sound system. Complimentary coffee and danish, an exhibitor's lounge, and a

snack bar will again be offered in the Exhibit Hall.

Parking & Transportation

Parking is readily available in downtown Louisville. The Hyatt offers enclosed parking for over 640 cars with additional parking available across the street and connected to the Commonwealth Convention Center by a covered walkway. There are numerous CITYPARK and other public parking garages conveniently located throughout the downtown area.

For a fun and fast way to get around downtown, the Toonerville II Trolley is available **free of charge.** Each of the nine trolleys is a detailed reproduction of streetcars used during the turn of the century that feature mahogany seats and woodwork along with gleaming brass hardware. The historic theme is carried out along the trolley route with authentically styled benches, planters, and street lamps.

Make plans now to attend your 1998 Annual Meeting—September 21-23!

"KEYS TO THE CITY"

For the convenience, relaxation, and enjoyment of meeting attendees and their guests, highlighted are a few "keys to the city of Louisville."

History & Population

Louisville's greatest natural resource, the Ohio River, is the reason for the city's existence. When early settlers began the westward expansion, the Ohio River was the primary water link between the West and the Northeast. A series of rapids along the route, however, forced settlers to disembark and portage around the falls. This stopping point became a strategic area for distribution and eventually grew into the city of Louisville, which was named in honor of King Louis XVI of France.

The metropolitan area of Louisville is comprised of Jefferson, Oldham and Bullitt counties in Kentucky, and Clark, Floyd, Harrison, and Scott counties in southern Indiana, totaling a population of approximately one million.

Events

Louisville hosts more than 40 outdoor festivals and events annually, but the city is most noted throughout the world for its incomparable Kentucky Derby and Kentucky Derby Festival. Louisville again is host of Equitana USA, America's first all-breeds horse show, and the Breeders' Cup in 1998.

Attractions

Louisville offers 80 exciting attractions, from relaxing cruises aboard the Belle of Louisville to the fast-paced excitement of Churchill Downs and the Kentucky DERBY! The Kentucky Derby is more than just the "Greatest two minutes in sports"—it is the greatest two weeks anywhere. The Derby Festival is a two-week whirlwind of more than 70 events that entertains more than 1.5 million people each year. The spectacular Thunder Over Louisville kicks off the festival, with one of the world's largest, if not the largest, annual fireworks display, bringing half a million people to the waterfront. The Derby Festival is packed with fun events like the Pegasus Parade, the Great Balloon Race, the Mini-Marathon, and the Steamboat Race between the Belle of Louisville and Cincinnati's Delta Queen. The two-week party culminates with a thrilling finish on Derby Day.

Arts

From the nationally acclaimed Actors Theatre to the elegance of the Louisville Ballet and Louisville Orchestra, Louisville's performing arts scene is thriving with opportunities. The Kentucky Art & Craft Gallery and Louisville Stoneware feature unique handcrafted pieces created by Kentucky artists using techniques passed down through generations.

What's New

Commonwealth Convention Center is set to expand to nearly 300,000 square feet by late 1999. Plans call for 150,000 square feet of contiguous, column-free exhibit space, an additional 50,000 square feet of ground-level exhibit space, a 30,000 square foot ballroom, and 55,000 square feet of meeting space.

The Louisville Zoo is in the midst of a long range, multi-million dollar expansion. The zoo's new *Islands!* Exhibit, highlighting the earth's most endangered habitats and species, is complete and the two-phase *African Outpost* is scheduled to open in 1998.

Kentucky Kingdom Thrill Park broke attendance records with *Chang*, the world's tallest, longest and fastest standup rollercoaster. The Thrill Park recently opened *Twisted Sisters*, the first pair of dueling roller coasters in the nation.

Louisville International Airport (SDF) completed the second of two parallel runways in January 1998. The $700+ million expansion has already generated additional flight service, bringing the total number of carriers to 17 and creating more than 10,000 new jobs. The new runways doubled the airport's capacity for passenger and cargo service.

The **Waterfront Development Project** has opened the first phase of the $60 million, multi-phased development and enhancement program for land along the banks of the Ohio River. The Children's Play area, Linear Park, the 4th Street Wharf, and the 13-mile Riverwalk were dedicated last fall. The remainder of Phase I, which includes the 11-acre Great Lawn, the Festival Plaza, and a

commissioned water sculpture will be completed by late 1998.

The **Louisville Slugger Museum & Bat Factory** produces one of Louisville's most famous products and pays tribute to the greatest sluggers in the history of the game with a variety of participatory exhibits. Tours of the bat factory have been rated among the top 10 industrial tours in the nation by *U.S. News and World Report*. The world's largest baseball bat, measuring 120 feet tall and weighing in at 68,000 pounds, marks the museum's home in the historic **West Main Street Cultural District**.

Louisville's newest riverboat, the **Spirit of Jefferson**, provides never-before-offered excursions on the Ohio River south of the McAlpine Locks. Smaller and faster than the Belle of Louisville, the new riverboat will be docked at Riverside, The Farnsley-Moremen Landing, a historic home in southwest Jefferson County, when its new dock is completed in the fall of 1998.

Visitor Information

The Convention Bureau's main information center is located in downtown Louisville at First and Liberty streets. It is open Monday through Friday 8:30 AM-5 PM; Saturday from 9 AM-4 PM; and Sunday and most holidays from 11 AM-4 PM. Other information centers are located off I-64 West near the Simpsonville Exit and at Louisville International Airport. Visitor information is also available at a kiosk in the Louisville Galleria, downtown.

For further information, please call 800.792.5595 or e-mail the Bureau at info@louisville-visitors.com. Visit their web site at http://www.louisville-visitors.com to review the **Online Guide to Greater Louisville**.

Watch for next month's *Journal* —
the Annual Meeting Issue of
The Journal of the Kentucky Medical Association!

The Annual Meeting issue of the *Journal* will feature a complete Preliminary Program of events, profiles of KMA officers and guest speakers, synopses of exhibitors, pull-out travel and parking maps, and many other highlights of this not-to-be-missed event!

Acute Pulmonary Histoplasmosis: Progressive Pneumonia Resulting from High Inoculum Exposure

Lee Tolar Meals, MD; W. Paul McKinney, MD

Dr Meals is a resident in Internal Medicine, Department of Veterans Affairs Medical Center, and Dr McKinney is a Staff Physician, Medical Service, Department of Veterans Affairs Medical Center, and Professar and Chief in the Divisian af General Internal Medicine, University af Lavisville, Lavisville, KY.

Histoplasmosis is endemic in certain areas of North, Central, and South America, especially within the Ohio and Mississippi River Valleys of the United States. We describe a case of histoplasmosis in a farm-dwelling resident of Kentucky who probably had multiple prior opportunities for exposure. However, during the gathering of topsoil containing chicken droppings for use as fertilizer, he was likely to have been exposed to such a high inoculum of the organism that he developed a severe pulmonary infection. He presented with a one-week history of malaise, myalgias, fever to 103° F, and headaches. A chest X-ray showed bilateral reticulonodular infiltrates. He was initially treated for community-acquired pneumonia. When his symptoms did not resolve, a bronchoscopy was performed. Washings from the broncho-alveolar lavage grew Histoplasma capsulatum, *and he responded well to itraconazole therapy. This case is presented to emphasize risks from high-inoculum exposure and the hazard imposed by harvesting certain types of organic material for use as fertilizer.*

Histoplasmosis is an infection caused by the dimorphic fungus, *Histoplasma capsulatum*. The initial site of entry is usually the lung.[1] Infection with this organism develops when the infectious microconidia of the mold phase are inhaled into the lungs, where they become pathogenic yeast-phase organisms.[2]

T-cell mediated immunity develops in 2 to 4 weeks in the immunocompetent host, and spontaneous clinical improvement generally follows.[2] However, the infection is not controlled in the HIV population where T-cell immunity is impaired.[3] Those with underlying lung disease are also at risk for chronic pulmonary histoplasmosis.[4]

Most symptomatic patients develop pulmonary symptoms with fever, cough, chest pain, and fatigue and usually recover without intervention; however, some remain symptomatic with fatigue and weakness for months.[5] Here we describe an immunocompetent individual with radiographic evidence of pneumonia who presented with fever, malaise, and headache and whose persistent symptoms were an indication for antifungal therapy.

Case Presentation

This patient, a 53-year-old white male, presented to the emergency room with a 1 week history of malaise, myalgias, headache, and fever to 103° F. He had been seen at another facility a few days earlier and treated with trimethoprim/sulfamethoxazole for pneumonia and sent home. He continued to have fever and chills despite antibiotic therapy. He denied nausea, vomiting, diarrhea, cough, dyspnea, congestion, nasal discharge, or photophobia. He complained that his headaches were worse with changes in position. He also reported a decrease in appetite.

He gave a history of a similar syndrome in his girlfriend approximately 1 to 2 weeks prior to the onset of his complaints. Her symptoms resolved spontaneously. He also gave a history of a tick bite to his left hip 2 weeks before he became ill. There was no history of joint pain, erythema, or rash.

His past medical history consisted of ventricular tachycardia controlled with medication, gastroesophageal reflux, benign prostatic hypertrophy, hearing loss, left foot injury in Vietnam, and degenerative joint disease. His list of medications included atenolol, doxazosin, mexiletine, docusate sodium, methocarbamol, and trimethoprim/sulfamethoxazole.

The patient retired from the military in 1985 and as a paint contractor in 1995. He and his girlfriend of 15 years live on a 20 acre farm in Kentucky where he gardens and cuts wood and grass. He denied any tobacco, alcohol, or illegal drug use.

On initial physical exam he had a temperature

of 101.8°F, a heart rate of 8l/min, and a blood pressure of 125/79 mm Hg with oxygen saturation of 92% on room air. There was tenderness over the left mastoid process without erythema or edema. Chest examination revealed only soft bibasilar crackles. The rest of his examination was unremarkable.

Laboratory findings showed a white blood cell count of 10,300/mm^3 with 45% segmented neutrophils, 15% bands, 23% lymphocytes, 4% monocytes, 8% atypical lymphocytes, 3% metamyelocytes, and 1% myelocytes. Hemoglobin, hematocrit, and platelet count were within normal limits. Blood chemistries were within normal limits except for an albumin of 3.4g/dL and an ALT of 46 U/liter. A chest x-ray showed bilateral reticulonodular infiltrates (see Figure 1).

The patient was admitted with presumed pneumonia and started on intravenous ceftriaxone and erythromycin. Doxycycline was added as coverage for possible tick-borne pathogens. Because the severe headache and mastoid tenderness led to the suspicion of meningitis or mastoiditis also, a lumbar puncture and mastoid x-rays were performed. Both yielded negative results. Since he developed daily temperature spikes up to 102°-103°F with persistent night sweats, he was questioned further about possible exposure to unusual agents. He reported that his girlfriend tended five caged doves housed in their barn. However, he described little contact with these birds. He also gave a history of gathering chicken droppings from the soil on a friend's property for use as fertilizer approximately 3 weeks prior to his illness.

A pulmonary consult was requested 48 hours after admission, and he was scheduled for bronchoscopy. A PPD skin test was placed and was negative, with positive controls. His chest CT revealed a large number of miliary lesions that were consistent with a granulomatous infection (see Figure 2). Blood cultures remained negative. There was no spontaneous production of sputum for analysis. Washings obtained during bronchoscopy were negative for acid-fast bacilli. However, special stains of transbronchial biopsy specimens revealed granulomas and budding yeast suggestive of cryptococcal infection.

His intravenous antibiotics were discontinued, and he was started on fluconazole 400 mg orally per day. His fevers resolved after 48 hours, and he was discharged home. Cultures of bronchial washings later grew *Histoplasma capsulatum*. He then was changed to itraconazole. During two clinic visits 6 and 9 weeks after the change to antifungal therapy was made, he was afebrile and feeling well off all antimicrobial medication.



Figure 1 — The patient's chest X-ray revealed bilateral reticulonodular infiltrates, predominantly in the lower lobes.

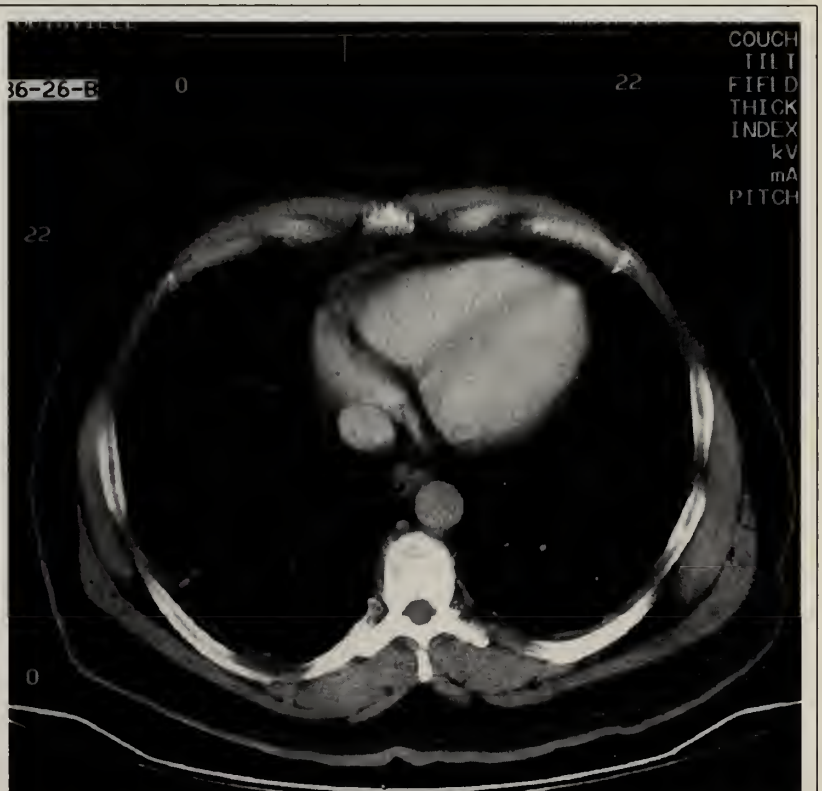


Figure 2 — A CT scan of the chest showed distinct nodular densities, consistent with granulomas, concentrated in the lower lung fields.

Discussion

Our patient had most likely been exposed to histoplasmosis in the past as he lives in the endemic Ohio River Valley region. Generally, less than 1% of persons infected after typical low-level exposure in these areas develop symptoms.[6,7] However, following high-inoculum exposure, the majority will develop symptomatic and often severe pulmonary infection, resulting in miliary or diffuse disease.[5] This patient almost certainly sustained just such a heavy fungal exposure while digging in the soil where he gathered the chicken droppings. The current public health recommendation for HIV-infected patients acknowledges this environmental risk by advising avoidance of exposure to sites likely to harbor high levels of *Histoplasma capsulatum*, such as chicken coops and bird roosts.[8]

The diagnosis in our patient was established by culture of brochoscopically obtained material. However, the diagnosis can sometimes be made by observation of the organisms on peripheral blood smear or bone marrow biopsy specimens.[9] Histoplasma Polysaccharide Antigen testing can also be performed and is recommended in cases of disseminated disease where the failure to make an early diagnosis may be fatal.[2]

While most persons with acute pulmonary histoplasmosis require no treatment, antifungal therapy is warranted for progressive acute pneumonia as well as chronic pulmonary or disseminated disease.[2] In patients with moderate to severe manifestations of disseminated infection, induction therapy with amphotericin B should be initiated; however, patients with less severe infection can be treated successfully with ketoconazole or itraconazole.[2] Itraconazole impairs the synthesis of ergosterol, promoting defective fungal cell membrane with altered permeability and function.[10] It has shown efficacy in immunocompromised patients, uncommonly produces side effects which would lead to non-compliance, and has few drug-drug interactions.[2,10] Fluconazole has proven to be only moderately effective and should be reserved for patients who cannot tolerate itraconazole.[11] Ketaconazole has been shown to be less effective in immunocompromised patients, has more side effects and more drug-drug interactions.[2] Thus, itraconazole appears to be a well-tolerated alternative for patients who do not require amphotericin B. It appears to be highly effective in daily doses of 200-400mg for progressive pulmonary histoplasmosis.[12]

References

1. Hay RJ. Histoplasmosis. *Semin Dermatol.* 1993;12:310-314.
2. Wheat J. Histoplasmosis: recognition and treatment. *Clin Infect Dis.* 1994;19(Suppl 1):S19-27.
3. Wheat LJ, Slama TG, Norton JA, et al. Risk factors for disseminated or fatal histoplasmosis. *Ann Intern Med.* 1982; 96:159-163.
4. Wheat LJ, Wass J, Norton J, Kohler RB, French MLV. Cavitary histoplasmosis occurring during two large urban outbreaks: analysis of clinical, epidemiologic, roentgenographic, and laboratory features. *Medicine.* (Baltimore) 1984;63:201-209.
5. Rubin H, Furculow ML, Yates JL, Brasher CA. The course and prognosis of histoplasmosis. *Am J Med.* 1959;27:278-288.
6. Wheat LJ. Diagnosis and management of histoplasmosis. Eur *J Clin Microbiol Infect Dis.* 1989;8:480-490.
7. Wheat LJ. Systemic fungal infections: diagnosis and treatment. I. Histoplasmosis. *Infect Dis Clin North Am.* 1988;2:841-859.
8. Hajjeh RA. Disseminated histoplasmosis in persons infected with human immunodeficiency virus. *Clin Infect Dis.* 1995;21(Suppl 1):S108-110.
9. McKinsey DS, Smith DL, Driks MR, O'Connor MC. Histoplasmosis in Missouri: historical review and current clinical concepts. *Missouri Med.* 1994;91:27-32.
10. Zuckerman JM, Tunkel AR. Itraconazole: a new triazole antifungal agent. *Infect Control Hosp Epidemiol.* 1994;15:397-410.
11. McKinsey DS, Kauffman CA, Pappas PG, et al. Fluconazole therapy for histoplasmosis. *Clin Infect Dis.* 1996;23:996-1001.
12. Dismukes WE, Bradsher RW Jr, Cloud GC, et al. Itraconazole therapy for blastomycosis and histoplasmosis. *Am J Med.* 1992;93:489-497.

Upper Airway Resistance Syndrome

Nuzhat Hasan, MD; Eugene C. Fletcher, MD

Many clinicians are familiar with the clinical symptoms and signs of obstructive sleep apnea (OSA). In its most blatant form, OSA is complete airway obstruction with repetitive, prolonged pauses in breathing, arterial oxyhemoglobin desaturation; followed by arousal with resumption of breathing. Daytime symptoms of this disorder include excessive daytime somnolence, intellectual dysfunction, and cardiovascular effects such as systemic hypertension, angina, myocardial infarction, and stroke. It has been recently recognized that increased pharyngeal resistance with incomplete obstruction can lead to a constellation of symptoms identical to OSA called "upper airway resistance syndrome" (UARS). The typical findings of UARS on sleep study are: (1) repetitive arousals from EEG sleep coinciding with a (2) waxing and waning of the respiratory airflow pattern and (3) increased respiratory effort as measured by esophageal pressure monitoring. There may be few, if any, obvious apneas or hypopneas with desaturation, but snoring may be a very prominent finding. Treatment with nasal positive airway pressure (NCPAP) eliminates the symptoms and confirms the diagnosis. Herein we describe two typical cases of UARS.

Obstructive sleep apnea (OSA) is usually described in obese patients who are habitual snorers. They frequently exhibit some anatomical abnormality of the soft palate or posterior pharyngeal air space, or perhaps a moderate overbite. A sub-group of patients suffer from excessive daytime somnolence and habitual snoring but do not have OSA. They are as incapacitated by their daytime sleepiness as are patients with OSA. Obesity may or may not be present. Overnight sleep study in these patients reveal short cyclic EEG arousals which frequently coincided with deep breaths. Between these deep breaths, the inspiratory air flow may be regular but lower than awake. These symptoms and characteristic polysomnographic findings have been labeled Upper Airway Resistance Syndrome (UARS). In spite of little evidence of anatomical abnormality of the upper airway and infrequent complete cessation of breathing, the patients have all of the symptoms of OSA.

We describe two patients who presented to the sleep disorders center at the University of Louisville with excessive daytime sleepiness which interfered with their daily routine. Both patients, women with moderate obesity but with stable weight for the last 6 years, reported these symptoms had been present for more than 20 years. A presumptive diagnosis of OSA was entertained in both patients. Each underwent overnight polysomnography (sleep study). These sleep studies did not show OSA but instead revealed snoring with multiple arousals from sleep. The diagnosis of UARS was confirmed by a second overnight sleep study. Using an esophageal catheter[1] to measure respiratory effort, a crescendo increase in the magnitude of negative intrathoracic pressure with each breath was seen. Subsequently, normal airflow was established following EEG arousal (Figure).

Case 1

CH is a 44-year-old female nonsmoker referred to the sleep clinic at the University of Louisville Hospital for severe daytime sleepiness. She had dozed off during important meetings at work and had difficulty keeping herself awake in the afternoon or in church. She had been a snorer since her teens. Her bed partner had noticed breathing cessation during sleep. He stated that the patient was a restless sleeper and thrashed around in bed. The patient felt very tired in the morning and often suffered early morning headaches. She had gained 20 lbs over the preceding year.

Physical exam showed an obese lady with a blood pressure of 110/80 mm Hg, a pulse of 80 beats/min, and a respiratory rate of 20 breaths/min. Weight was 210 lbs, height 5´2˝. The oropharynx was normal. The chest was clear to auscultation and percussion. Cardiovascular system exam was normal. Sleep study revealed an apnea/hypopnea index of 2.7 events/hour (normal). Oxygen saturation was 96% throughout the night. A sleep study with esophageal catheter in place for

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measurement of intra-thoracic pressure was repeated on a subsequent night. This study revealed progressive increase in negative esophageal pressure, followed by EEG arousal with normalization of esophageal pressure and airflow (Figure).

Case 2

MB is a 57-year-old lady evaluated for excessive daytime sleepiness. She usually required a nap in the afternoon and felt refreshed after the nap. Her normal bedtime was 11 pm and she usually awakened at 6 am. She complained of disturbed sleep, waking several times each night, and feeling very tired in the morning. She often snored at night. Her weight was stable over the last 6 years. Her past medical history was significant for obesity, diabetes mellitus, degenerative joint disease, and claustrophobia.

Physical examination revealed an obese lady with a blood pressure of 120/76 mm Hg, a pulse of 88 beats/min, and a respiratory rate of 14 breaths/min. Her height was 5´7˝ and she weighed 222 lbs. No abnormality was appreciated in the oropharynx. Her chest was clear to auscultation and percussion and the cardiovascular system exam was within normal limits.

Laboratory polysomnography showed an apnea/hypopnea index of 1.2 events/hour. She had 52 leg movements per hour. Minimum oxygen saturation was 90%. Repeat polysomnography with esophageal balloon catheter showed progressive increase in negative esophageal pressure with associated arousals on EEG. The arousals coincided with termination of the obstructive breathing. Multiple similar events were seen throughout the night.

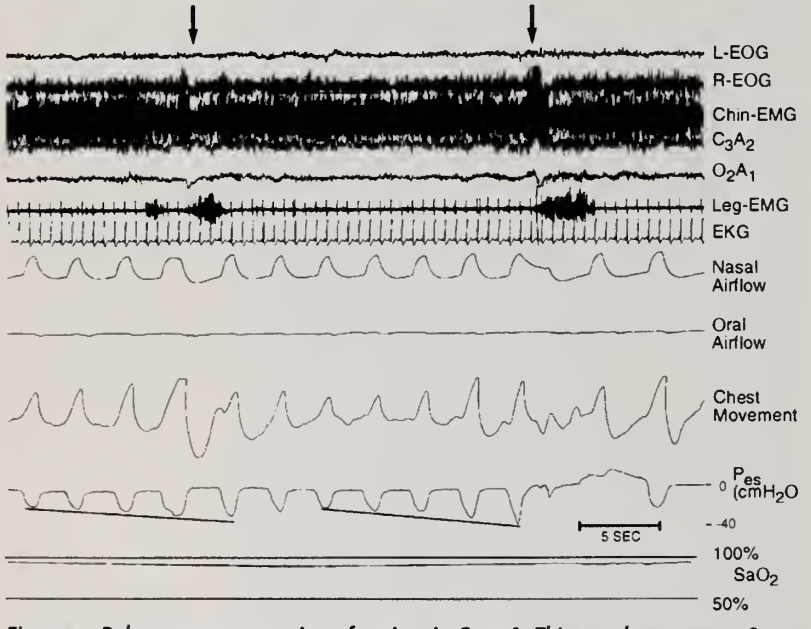


Figure — Polysomnogram tracing of patient in Case 1. This epoch represents Stage 1 sleep. From top to bottom the channels represent: L-EOG and R-EOG, left and right electroocculogram; Chin-EMG, electrodes placed over chin reflecting tongue activity; C_3 A_2 and O_2A_1, frontal and occipital electroencephalographic leads respectively; leg EMG, electrodes placed over pretibial area; nasal and oral airflow; airflow from the nose and mouth measured by thermistor placed on the upper lip; chest movement; movement of the chest wall measured by respiratory strain gauge; Pes; Esophageal pressure measured by balloon catheter; SaO_2; oxyhaemoglobin saturation measured by finger pulse oximeter (showing no appreciable desaturation). The sloping lines drawn in the Pes channel outline the crescendo slope of negative intra-thoracic pressure associated with increased respiratory effort. Large arrows at the top of recording indicate EEG arousals followed by increased thermistor airflow. In UARS (Upper airway resistance syndrome) there is an increase in respiratory effort reflected by crescendo increase in negative intra-thoracic pressure, culminating in EEG arousal with restoration of thermistor airflow.

Discussion

OSA is usually reported in obese men who are habitual snorers with associated complaints of excessive daytime sleepiness.[2] They often doze if they are inactive: at social gatherings, at work, and frequently while driving motor vehicles. A recent survey reported a 7.2 fold higher rate of traffic accidents in sleep impaired drivers.[3,4] Epidemiologic surveys have revealed that nearly 3.7% to 4.2% of the general population in western countries are affected by daytime hypersomnolence.[5] Young and colleagues have concluded that 4% of middle age men and 2% of middle age women suffer from excessive daytime somnolence due to OSA.[2] The diagnostic test for sleep-disordered breathing is a sleep polysomnogram (sleep study). During this study, oxygen saturation, airflow, electroencephalogram (EEG), and chest and abdominal movement are monitored during nighttime sleep. A decrease or cessation of air flow together with decrease in oxygen saturation is counted as an abnormal respiratory event (apnea or hypopnea). More than five events/hour during sleep is presumed abnormal.

Excessive daytime sleepiness can be a presenting symptom in OSA, narcolepsy, insomnia, and idiopathic hypersomnolence. Excessive daytime somnolence without apnea but with snoring has been observed.[6] The sleep study may show less than five events/hour with minimal or no oxygen desaturation. The only abnormality recorded during the sleep study can be multiple EEG arousals lasting 3 seconds or more. These arousals are associated with abnormally deep negative inspir-

atory efforts with mild decrease in inspiratory air flow. The sleep study shows no evidence of overt apnea or hypopnea. Therefore, this syndrome has been labeled as UARS by Guilleminault et al who first described it.[6,7] These authors studied a large population of patients referred to the Stanford sleep disorders center with a diagnosis of "idiopathic hypersomnolence." They identified a sub-group of non-obese subjects with daytime somnolence and snoring but without evidence of apnea. They propose the criteria in Table 1 for the diagnosis of UARS.

Table 1. Criterio For Diognosis of Upper Airway Resistonce Syndrome

1.	Severe daytime somnolence
2.	Tronsient repetitive EEG orousols losting 3 to 10 seconds
3.	Increase inspiratory effort linked to orousols, evidenced by high intro-thorocic pressure variotion
4.	Slight reduction in tidol volume preceding on orousal
5.	No oxyhemoglobin desoturotion

Table 2. Presenting Complaints of Patients with Upper Airway Resistance Syndrome

1.	Tiredness, fotigue ond excessive doytime sleepiness
2.	Dryness of mouth or throat during the night or upon owokening
3.	Eorly morning heodaches or feeling of heaviness
4.	Nocturio
5.	Borderline high or high blood pressure
6.	Nocturnol bruxism
7.	Symptoms of reflux, eg, heartburn or ocid toste in the mouth
8.	Sociol isolation
9.	Amenorrheo or dysmenorrheo in women

Many women, later diagnosed with UARS, may first present to their primary care physician with symptoms of tiredness or fatigue in contrast to patients with sleep apnea who often present with excessive daytime sleepiness.[6,7] At Stanford sleep disorders center, women suffering from UARS often present with multiple complaints (Table 2). The duration of symptoms before referral to a sleep center for a sleep related disorder was 9.7 years. Sleep related problems were recognized more quickly in elderly or in obese women than in middle age or non-obese women. Guilleminault et al also report a relationship between hypertension and UARS.[8]

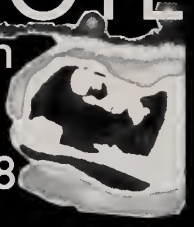
CPAP (continuous positive airway pressure) is the treatment of choice. It is used to overcome the upper airways resistance. The level of pressure used is individualized by titration performed in a sleep laboratory to eliminate snoring and arousals. Continuous use of CPAP usually ameliorates the symptoms of UARS.

References

1. Baydur A, et al. Simple method for assessing the validity of the esophageal balloon-catheter technique. *Am Rev Respire Dis.*1982;129:788-791.
2. Young T, Palto M, Dempsey J, Skatrud J, Weber S. The occurrence of sleep disordered breathing among middle aged adults. *NEJM.* 1993;328:1230-1235.
3. Findley LJ, Levinson MP. Driving performance and automobile accidents in patients with sleep apnea. *Clin Chest Med.* 1992;13:427-435.
4. Findley LJ. Drivers with untreated sleep apnea. *Arch Intern Med.* 1991;151:1451-1452.
5. Guilleminault C, Stoohs R, Duncan S. Snoring-daytime sleepiness in regular heavy snorers. *Chest.* 1991;99:40-48.
6. Guilleminault C, Stoohs R, et al. Upper airway sleep-disordered breathing in women. *Ann Int Med.* 1995;122:493-801.
7. Guilleminault C, Stoohs R, Alex C, Maistros P. A cause of excessive daytime somnolence. The upper airways resistance syndrome. *Chest.* 1993;104:781-787.
8. Guilleminault C, Stoohs R, Shiomi T, Kushida C, Schnittger I. Upper airway resistance syndrome, nocturnal blood pressure monitoring and borderline hypertension. *Chest.* 1996;5-109:901-908.

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A Physician Leadership Training Initiative

The rapid changes in health care organizational structures, insurance mechanisms, payment strategies, and oversight of physicians' work provide challenges to health care organizations. Each year, fewer physicians are practicing their profession in the traditional solo office environment. Now their practices are being consolidated, combined into single and multispecialty group practices, or purchased. Physicians are increasingly practicing in integrated delivery systems, in which the provision of services by diverse practitioners is coordinated under central financing and administration. In the integrated delivery system work environment, clinical outcomes and the financial well-being of the system depend on the performance of all professionals in the system. The observation and measured assessment of an individual physician's work is common, and the use of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) concepts to facilitate physician collaboration is frequent.

In recent years, many have advocated a new form of physician leadership within the newly evolving health care environment.[1,3] Merry[1] writes, "Increasingly physicians must define themselves as leaders in the context of organizational settings such as hospitals, group practices, medical associations, integrated delivery systems, and so on. In this context, the notion of leadership implies not simply clinical competence but the ability to motivate a group of peers to achieve particular organizational purposes." In addition to motivational and visionary abilities, other skills and knowledge are required for the successful physician leader. These skills include knowledge of human management, including negotiation, conflict resolution, team-building, and organizational "politics"; knowledge of finance, accounting and data management; and the ability to use strategic planning skills and quality process skills (ie, TQM, CQI).[2,4]

Traditional medical schools and residency training programs do not adequately provide physicians with the knowledge and skills listed above; thus, they poorly prepare physicians for the new leadership role required of them in current health care settings. To address the learning and training needs of physicians who have achieved leadership positions or are interested in assuming such a role, educational resources are increasingly available. The American College of Physician Executives offers the Physicians in Management program and a certification process. The American College of Executives provides several educational offerings. Several years ago, the University of Wisconsin created an advanced management degree program designed for physicians.[1] Other educational options for physicians interested in management include the completion of a Masters in Business Administration (MBA) degree, and several universities and colleges are beginning to offer MBA degree programs tailored to physicians' needs.

At the University of Kentucky, the recognition that physicians need new leadership competencies has recently fostered the establishment of an innovative educational opportunity for physicians and other health care professionals. The Certificate in Medical Management (CMM) program consists of specialized course work that focuses on the acquisition of fundamental business and management skills for effective business leadership in the health care environment. The program is designed both to develop institutional physician leaders and other key health care personnel and to initiate necessary changes in the behavior of physicians and other health care personnel that will allow the academic and integrated health care delivery system to suceed in the 21st century. In this correspondence, we describe how the CMM was established, the CMM itself, and its unique position in the field of physician leadership training.

The impetus for the CMM was informal discussions among physicians and hospital administrators about the need for increased physician leadership within the medical center. It was recognized that these leaders required skills, including basic management techniques, that were different from those traditionally possessed by academic leaders (usually clinical and academic productivity). Initial meetings were held between key faculty members in Hospital Administration, the College of Medicine, the Chandler Medical Center Chancellor's Office, the College of Business and Economics, and the College of Allied Health Professions. Although an ad hoc committee composed of people representing these entities was established, one person (RWS) was given the charge by the Chancellor and the Hospital Administration to "drive" the process. The committee's charge was to draft a University of Kentucky in-house educational program intended to educate physician leaders, including educational objectives for the program and the logistics of program administration.

The professional responsibilities of physicians and the time demands placed on them presented a challenge to the committee in determining what would be the most valuable learning experience for the proposed audience.

Specific features of an educational program that committee members believed were necessary included the following: (1) relevance of the program's instructional material to the health care environment so that participants would be easily engaged; (2) scheduling of course time so that interference with clinical responsibilities would be minimal; (3) scheduling of course time so that family and personal life would not be greatly disrupted; (4) location of courses away from the medical center to create a learning atmosphere divorced from the clinical setting; (5) a time frame for the educational experience that would maximize acquisition of key physician leadership and business competencies but would not be excessively lengthy; (6) the provision to participants of a tangible acknowledgment of their learning experience (ie, plaque, certificate); and (7) the possibility of using the learning experience as a stepping-stone to an advanced degree, such as an MBA degree or a Masters in Health Administration (MHA) degree.

Committee members agreed that the initial participants in the educational program should be invited to participate on the basis of their experience and their roles in the institution. Future classes would be open to interested participants, including those from other health care professions. Several committee meetings throughout the winter and spring of 1997 led to plans for course work that would enable participants to complete an academic certificate, the Certificate in Medical Management, related to health care management. The certificate's required curriculum would combine courses from the College of Allied Health Professions and the College of Business and Economics. Class times for the courses would be structured in a unique fashion. Initial funding for the CMM would come from the Hospital Administration and the Chandler Medical Center; additional funding for this educational program and related activities would be sought from other sources. It was agreed that the College of Business and Economics would be responsible for administrative coordination of certificate activities. The College of Graduate Studies would provide academic oversight for the CMM.

Description of the Certificate in Medical Management

The CMM curriculum is designed to provide health care practitioners with an educational experience that prepares them for effective business leadership in the constantly changing health care environment. The program emphasizes business and management principles within the unique context of health care delivery systems. The specific objectives of the Certificate are the following:

1. Acquiring fundamental business and management skills and the ability to apply them within an integrated health care delivery system;
2. Understanding the financial and market forces within the health care environment;
3. Understanding and being able to apply quality improvement concepts to health care, including theory, process analysis, and clinical pathways;
4. Understanding the current health care environment, including organizations, trends, and legal and ethical issues;
5. Gaining skills to be effective team leaders and change managers, with knowledge of organizational behavior, effective communication, negotiation, and conflict resolution;
6. Developing a cadre of institutional change agents.

The certificate curriculum is delivered through 12 required graduate-level courses with joint instruction by faculty from the College of Allied Health Professions and the College of Business and Economics. Four separate courses are integrated into appropriate modules over two semesters. The duration of each module is 2 to 4 hours. The specific courses are (1) Overview of the Health Care Delivery System, (2) Organizational Behavior, (3) Managerial Economics, and (4) Introductory Accounting.

To accommodate the schedules of clinical faculty, class times are spread throughout the semester. Each day includes 7 hours of class work, lunch for the participants, and a mid-morning and mid-afternoon refreshment break. In addition to this required class time, two additional Fridays per semester are scheduled for participants to engage in exercises and discussions related to topics and issues not fully explored within the context of the courses. The logistics of this schedule allow the physician participants (and, in the future, key health personnel) the time necessary to maintain dedication to patient care and to complete the CMM. The courses are held at the College of Business and Economics, which is located in a building that is physically separated from the Medical Center but that provides participants with ready access to parking and other academic resources.

The material discussed on the additional Fridays that are not devoted to course work include managed-care issues, conflict resolution, team-building, situational leadership, and the Stephen Covey course, the "Seven Habits of Highly Effective People." Experts from within and outside the University of Kentucky are present to discuss these topics with participants during the designated sessions. In addition to required course readings, between the CMM semesters the participants read the books *Built to Last*,[5] and *Market-Driven Health Care*.[6]

The CMM is evaluated through a variety of measures. Participants complete surveys before matriculation, immediately after completion of the course, and 1 year after completion of the course. These surveys, based on the

work of David Kindig (1989), list 32 key management competencies for physicians and ask participants the following questions: (1) Do you believe that this is a key management competency for physician managers? and (2) How much does your daily work currently require the competency? Examination of responses will focus on respondents' changing understanding of the importance of these competencies and the extent to which their jobs require these competencies. In addition to the surveys of CMM participants, other data will be collected regarding changes in CMM holders' job titles and organizational roles, as well as the number of masters degrees completed.

To enhance the benefits of the certificate for its holders, 9 graduate-level hours (excluding credit from the Introductory Accounting course) from the regularly scheduled courses required to complete the Certificate may also be applied toward either an MBA degree or a MHA degree. In this manner, physicians and other key health care personnel who are interested in continuing their education are supported in the timely completion of the degree.

All of the 1997 matriculants in the CMM program are physicians from the College of Medicine. The specialties and the academic and institutional experiences and roles of these participants are varied; assistant, associate, and full professors participate in the courses. These participants were invited by the Dean of the College of Medicine and by their respective department chairs to participate so that a cadre of physicians could be developed within the institution who would be prepared to lead in a time of change in the health care environment. It is anticipated that, beginning with the second year of certificate course work, a transition will occur toward participants associated with "product lines," such as key personnel involved in the administration of the operating room, the pharmacy, etc. Including participants from these fields in the program will help build efficient, skilled team members capable of effective functioning in the current health care environment.

The CMM is planned to be the third level of a five-tiered program being developed by the University of Kentucky Chandler Medical Center, in conjunction with the College of Allied Health and the College of Business and Economics. The purpose of this program is both to educate all employees and students of the Medical Center about the current health care market and the corresponding environment, and to build appropriate leadership. The anticipated levels of the five-tiered program are as follows:

Level 1: core education for all employees and students of the Medical Center, including the Colleges of Allied Health, Medicine, Dentistry, Nursing and Pharmacy;

Level 2: a leadership week (40 hours) for 30 people offered twice per year that simultaneously serves as an entree to the CMM;

Level 3: the CMM;

Level 4: an advanced degree (MBA, MHA, etc), and

Level 5: continuing medical education on a routine basis for graduates of Levels 3 and 4 for the purpose of maintaining and enhancing *esprit de corps,* focus, core purpose, vision, and health care education.

The University of Kentucky CMM offers several advantages for the institution and for the participants that are absent from other physician leadership programs in the nation. First, the matriculation of 20 to 25 participants through the Certificate program each year quickly creates a critical mass of "change agents" within the institution. Second, the associated costs incurred by extra-institutional programs for both participants and the institution are significantly reduced. The estimated total cost per participant for the CMM is $4,600; this figure includes expenses for overload salaries and fringe benefits for faculty teachers, staff support for the certificate courses and activities, textbooks for each participant, miscellaneous supplies for participants (notebooks, calculators, duplicating, etc), teaching supplies and rentals of audiovisual equipment, and meals and refreshments on class days. The routine cost for similar extra-institutional programs (including travel) is $25,000 per annum.

Third, the CMM allows the effective study of changes in course sequence and content. Fourth, the in-house program can be easily tracked from a quality-assurance standpoint. Fifth, an effective core group of educators necessary for implementing change relevant to the dynamic health care climate can be developed. Sixth, grouping key personnel in the large medical center (physicians, nurses, administrators, pharmacists, etc) is practical by using "product lines" to incorporate the fundamental business and financial expertise necessary to deliver cost-efficient care in a quality manner. Seventh, institutional leaders can be developed who share a core vision and purpose so that continuity and stability can be provided for the institution in a constantly changing health care environment. This advantage is in contrast to the frequent academic practice of continually recruiting leadership from outside the institution because of a perceived lack of qualified leadership within the institution. Finally, and most importantly, the CMM concept is readily transferable to other large institutions with similar academic resources; thus, it is possible to initiate widespread development of the necessary leadership and financial skills of physicians and other key personnel that are necessary if the AMC and similar integrated health care delivery systems are to survive and thrive.

In summary, the Colleges of Medicine, Allied Health Professions, and Business and Economics at the University of Kentucky have developed

a unique program for training and creating a core group of institutional leaders for the academic medical center. Because of the intense interest the CMM has already generated at the national level, it is anticipated that the UK CMM will become the national model for such programs.

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References

1. Merry MD. Physician leadership for the 21st Century. *Quality Management in Health Care*. 1993;1(3):31-41.
2. Farrell JP, Robins MM. Leadership competencies for physicians. *Healthcare Forum Journal*. 1993;July/August:39-42.
3. Bachrach DJ. Developing physician leaders in academic medical centers Part 1: Their changing role. *MGM Journal*. 1996;(November/December): 35-48.
4. Treister NW. Development of a local physician executive leadership program. *Physician Executive*. 1995;21(40):22-23.
5. Collins JC, Porras JI. Built to Last. New York: Harper Business, 1997.
6. Herzlinger R. *Market-Driven Health Care*. New York: Addison Wesley Publishing Co. 1997.



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AMERICAN MEDICAL WRITERS ASSOCIATION

Provider? —Not Me!

"I will not allow a business to depersonalize the relationship that I have with my PATIENTS as their PHYSICIAN, and all that that entails at any hour of any day."

When a majority seeks to eradicate a minority one of its first acts is to remove the minority's identity. For example, in Dachau or Vietnam POW camps you became a number—not a name, not a rank, not a person. It is much easier to beat senseless someone who is depersonalized, someone who is not Johnny's daddy, Sarah's sister, . . . or Martha's doctor. It might be paranoid to assume enough importance to warrant a systemized search and destroy mission on the part of third party interests, but just because you're paranoid doesn't mean they're not out to get you. It is in the interest of physicians, therefore, to reacquaint themselves with who they are, from where they have come, and what they mean to society.

God forbid you should call me a provider. A provider is to medicine like a Coke machine is to a can of Coke. Money goes in, and a generic, uniform product comes out. You want a straw, a Pepsi, or only have half as much money as needed? Forget it. Service denied. You're really thirsty, but your specific gravity is less than 1.032, you actually have saliva, and you had a Coke last week? Sorry, the doctor from California says your Coke is unnecessary and wasteful. Equating a physician to a provider is a managerial, business buzzword, and it is just plain wrong.

Why? Because by generically labeling the complex, intensely private, multilayered relationship that you have with a patient as a single thing—a product, you demean its importance, both to the patient and the physician. This is a strategy by insurers to shift health care decision making to themselves, a 'spin' to portray physicians as simply cogs in the wheels and not the axles which make all of the wheels turn. If the insurers were to disappear tomorrow, myocardial infarctions, bowel obstruction, and breech presentations would all still occur, and doctors would be in attendance. If doctors were to disappear tomorrow, some unsupervised care might be rendered, but medicine as we have come to expect and appreciate, would no longer be practiced. Defining what the profession of medicine does as simply a commodity is shortsighted, but for insurers, economically advantageous. Physicians have never been defined by how we were paid. If the public really believes that we are more interested in dollars and profiles, than in doing what is right for them, the insurers have won the spin war. We have allowed them to interpose themselves between the patient and the doctor, and we should rail against the thousands of times it will happen in the future. If you as a physician, you as Marcus Welby, disappear from the equation, you become about as important, lovable, approachable, vital, and integral as the guy behind the counter at the county clerk's office. The only group that will suffer from this more than the profession of medicine are the patients themselves.

You see, try as they may, business cannot get you out of the picture, unless you let yourself and your profession fade into anonymity. Unless you buy that pathetic myth that we are workers just like everyone else. Because I don't know about you, but I didn't go into this field to be like everyone else. I didn't pull every other night all-nighters so I could ace some

"Equating a physician to a provider is a managerial, business buzzword, and it is just plain wrong."

biology final, so that I could take the 8 hour MCATS, so that I could compete with 12 other people to get my interview spot, so that I could sweat a 3 hour grilling to prove that my interests in the medical profession were pure, so that I could put in a hundred hours a week in residency making less than minimum wage, so that I could watch a newborn die or a mother bleed out in the emergency room, so that I could tell someone they had ovarian cancer, so that I could miss my anniversary to be at the delivery of my first set of twins, so that someone could tell me I am a provider, a marketable and an expendable commodity. I will not allow a business to depersonalize the relationship that I have with my PATIENTS as their PHYSICIAN, and all that that entails at any hour of any day.

Physicians must not lose sight of what it means to be in a profession. We did not enter this profession for economic gain. Physicians are, overall, some of the smartest people around, and clearly, there are much better places to make money. There is, however, no better place to make a difference. A provider no longer tries; Martha's doctor cannot stop trying.

Kimberly A. Alumbaugh, MD

Givers or Takers—a Choice



Jan Crase
KMAA President 1998-99

Often it seems there are two kinds of people in the world, **givers** and **takers.** While these are extremes in behavior, there is simply a choice between them. Which do you choose?

By and large, physicians are some of the most caring and giving people in our society. They give of their material wealth, but more importantly they give of themselves. We all have known many physicians who give tens of thousands of dollars in free services plus help fund charities in their own communities as well as state and national charities. Many times these physicians are even anonymous in their giving. The Alliance chooses to give and care as an organization and works on many worthwhile health promotions as well as many community causes. I applaud and commend the generosity of physicians and their spouses. They are indeed caring people who deserve the utmost of respect from their fellow citizens for choosing to share.

Today, many physicians' incomes are being reduced by HMOs, insurance companies, and government, and at the same time more restrictions are being placed upon them by these same entities. Physicians are becoming more stressed and frustrated with additional paper work, rules, regulations, threats of malpractice, and other superfluous things, all of which only detract from patient care. Under such circumstances, "just getting through the day" sometimes becomes a challenge, and it is easy to become a taker instead of a giver. Please do not choose to become a self-centered taker. We *grow* by serving others, and growth must continue if the full possibilities of our lives and this profession are to be realized.

Dr Fosdick says in, *The Meaning of Service,* "The Sea of Galilee and the Dead Sea are made of the same water. It flows down, clear and cool from the Hermon and the roots of the Cedars of Lebanon. The Sea of Galilee makes beauty of it, for the Sea of Galilee has an outlet. It gets to give. It gathers in its riches that it may pour them out again to fertilize the Jordan plain. But the Dead Sea, with the same water, makes horror. For the Dead Sea has no outlet. It gets to keep. That is the radical difference between selfish and unselfish people. We all do want life's enriching blessings; we ought to—they are divine benedictions. But some people get to give and they are like Galilee; while some people get to keep and they are like the brackish water that covers Sodom and Gomorrah." Our most valuable possessions are those which can be shared; and when shared, multiply. Our least valuable are those when divided, diminish. Service does not have to be spectacular to be effective. Service rendered unto others must be thoughtful, however, otherwise our attempts may do more harm than good. Many people ignore the fact that service in little things may be more monumental than the spectacular wealth of Kubla Khan placed upon an opaque alter. Remember the widow who gave the small amount of change as her offering? The greatest service we can render is simply to share, of ourselves, our ability, our courage. In so giving, the greater becomes our capacity to give. To share is not a task, but a golden opportunity wherein an abundant life is realized.

Most of us were fortunate enough to be the benefactors of many positive influences in our own lives as a result of the generosity of others that cared enough to share. Today's youth are having many more darker experiences and challenges than we ever imagined as children. With the prevalence of violence seemingly everywhere—on TV, on the Internet, in gangs, at school, and all too often in the home—it has become a temptation for every child to participate in violent behavior on some level. After all, the average school age child watches 24 hours of TV a week and has witnessed 200,000 acts of violence by the time he/she graduates from high school. Violence has surpassed disease as the number one killer of children—violence is today's number one health crisis—violence is one of the most profound yet preventable health epidemics of our time and yet violence is a **chosen** behavior. Just as we must make choices, today's children must make choices also. We all feel better about ourselves when we make positive choices.

The KMA Alliance is working with a project that we hope will help Kentucky's children make positive choices and avoid choosing violent behavior. If we can start with the children perhaps we can help stop the chain of family violence that seems to continue from generation to generation. "Stop America's Violence Everywhere" is a nationwide effort of physicians' spouses to combat violence. Some wonderful materials have been developed by the AMA and the AMAA that teach children kindergarten through 3rd grade how to solve problems without resorting to violence; how to treat others with respect including siblings, friends, and parents; and about making positive choices in what they do. These materials have been used in pilot projects throughout the country with very positive response on the part of teachers, councilors, principals, superintendents, parents, children, and everyone who has seen them. The KMAA wants to get these anti-violence materials including the "Hands are NOT for Hitting" place mats and the "I Can Choose" coloring-workbooks in the hands of all Kentucky children K-3 as soon as possible.

Obviously, distribution in 120 counties would be prohibitive for the Alliance, which is not organized in all those counties. The Cabinet for Families and Children is willing to distribute these materials and work with the Family Resource Centers, school councilors and teachers in each of the public schools to see that the materials get the maximum exposure and use by the children. Alliance members are encouraged to participate in the distribution also. These materials should be distributed at the beginning of the school year so they can be used and referred to throughout the school year. Some of these materials were distributed in some counties this spring, so to avoid duplicating services, and wasting money, September's distribution should dovetail with the spring effort.

An endeavor of this magnitude is a challenge and requires cooperation and efforts of many people to accomplish. I hope all counties will consider this a worthwhile effort and participate at whatever level they feel comfortable. It is also hoped that you physicians will support this project. If your county is participating, please help in whatever way you can. If your county does not have an organized Alliance, you are welcome to participate on your own. Your thoughts, ideas, and suggestions are solicited for this project and for all other activities of the Alliance. Please feel free to call or write to me about your visions or hopes for this Alliance in the future.

Working together, we can help stop the cycle of violence so our children can enjoy lives that are safer, healthier, and more civilized. It is most appropriate that the KMA and KMA Alliance be the leaders and one of the most powerful voices in the state in opposing violence and educating the public. After all, we choose to be givers! What greater way to give than to a child at an age when you can have the greatest impact? If you have interest in promoting this project or wish to make a contribution, the Alliance will be happy to act as your agent in getting this done. We can choose to help make a difference!

Jan Crase
KMAA President



Nancy W. Dickey, MD, President American Medical Association

Keynote Speaker — KMA House of Delegates



Nancy W. Dickey, MD, President of the American Medical Association (AMA), is the keynote speaker at the Kentucky Medical Association Annual Meeting at the opening House of Delegates on September 21, 1998. Dr Dickey is a board-certified family physician from College Station, Texas. She has been a member of the AMA Board of Trustees since 1989. She served as vice chair from 1994-95, chair from 1995-97, and President-Elect in 1997.

Prior to her election to the Board, Dr Dickey served on numerous committees, beginning in 1979 as a member of the AMA Ad Hoc Committee on Women in Organized Medicine. She is a Fellow of the American Academy of Family Physicians and served as Vice President of the Texas Medical Association in 1986-87.

A graduate of the Stephen F. Austin State University, she received her medical training at the University of Texas Medical School at Houston, where she was a recipient of the Distinguished Alumni Award. She has served as reviewer for *JAMA* and on the editorial advisory boards of *Patient Care, Medical World News,* and Medical Ethics Advisor. She currently serves on the editorial board of *Archives of Family Medicine.*

Dr Dickey has taken an active role in various community activities including coaching in a youth soccer league and as a sponsor for the United Methodist Youth Fellowship. She is a member of the Christ United Methodist Church in College Station.

Dr Dickey and her husband, Franklin (Champ), have three children.

PEOPLE

Timothy S. Prince, MD, has been selected for advancement into the 1998 Class of Fellows and Masters in the American College of Occupational and Environmental Medicine (ACOEM), an international medical society of 7,000 physicians who champion the health and safety of workers, workplaces, and environments. Dr Prince is an Assistant Professor in the Department of Preventive Medicine and Environmental Health at the University of Kentucky.

Norbert Burzynski, MD, Sofia Franco, MD, and Charles E. Wagner, MD, are among the University of Louisville faculty members recently nominated by their peers to receive President's Awards, the university's highest honor for faculty.

Dr Burzynski was recognized for his knowledge in the prevention and treatment of oral cancer, which has helped him land more than $1 million from the National Cancer Institute. The money in turn has financed a student research fellowship for more than 20 years. His dedication to oral and related cancer research is why the US Centers for Disease Control and Prevention tapped him to serve on a panel about oral cancer.

Dr Franco was recruited to U of L in 1972 as assistant professor of pediatrics and medical director of the Children and Youth Project, which provides care to high-risk infants and children. Dr Franco is credited with "extending her commitment of time and expertise beyond her role within the School of Medicine to several agencies devoted to the welfare of children." She serves on the KMA Community and Rural Health Committee and helped design an immunization information system for state government. Other committee work includes service on the indigent care committee of the Jefferson County Medical Society and the lead screening program for the Louisville and Jefferson County Board of Health. Since 1980 Dr Franco has been actively involved in the Home of the Innocents.

Dr Wagner, who was recruited to U of L as an instructor in anatomy in 1952, currently holds the appointment of emeritus professor of anatomical science and neurobiology. In his 45-year career at U of L, he has taught a variety of courses at the Health Sciences Center in the fields of allied health, nursing, and dentistry. Dr Wagner has served for many years as the School of Medicine's assistant dean for admissions and student affairs and as associate dean of admissions. He has authored and contributed to several important educational publications. Over the years, his many honors include the American Medical Student Association's Golden Apple Teaching Award of 1989-90.

Charles J. Bisig, Jr, MD, has been elected Secretary-Treasurer and President-Elect of the Louisville Surgical Society for 1998. His father, **Charles J. Bisig, Sr, MD,** served as president of the Society in 1992.

Ronald L. Levine, MD, has been named president of the American Association of Gynecologic Laparoscopists (AAGL). Under his leadership, the nearly 6,000 physician members will be promoting the therapeutic benefits of minimally invasive surgery.

Dr Levine has been instrumental in developing and employing new surgical theories and instruments for surgical endoscopy. Author of several books, journal articles and reports, he published the first American report of laparoscopic bilateral oophorectomy, a specialized procedure for removing both ovaries.

UPDATES

AMA Names New Chief Executive

E. Ratcliffe "Andy" Anderson, Jr, MD, was selected by the AMA Board of Trustees as its new Executive Vice President. Dr Anderson, a former US Air Force Surgeon General, will assume AMA leadership this summer.

The 58-year-old dermatologist is professor of medicine at the University of Missouri-Kansas City School of Medicine and is CEO of Truman Health Systems. A graduate of the Louisiana State University School of Medicine, Dr Anderson completed postgraduate work at Philadelphia General Hospital, Boston City Hospital, and NYU Medical Center.

1998 Projects for OIG Target Fraud & Abuse Areas

Each year the Department of Health and Human Services (DHHS), which oversees the Medicare program, drafts a "work plan" for its Office of Inspector General (OIG). This work plan highlights the major focus for use of OIG resources and provides a brief description of various project areas for the OIG. Much of the report focuses on potential OIG concerns in the areas of fraud and abuse in the Medicare system. The following are excerpts from the work plan that discuss the OIG's emphasis for 1998 on physician services within the Medicare system. The entire report can be obtained from the DHHS website at http://www.dhhs.gov/progorg/oig/.

- **Physicians at Teaching Hospitals (PATH)**

This initiative is designed to verify compliance with the Medicare rules governing payment for physician services provided in the teaching

setting and to ensure that claims accurately reflect the level of service provided to the patient. The PATH initiative has been undertaken as a result of the OIG's audit work in this area which suggested that many providers were not in compliance with the applicable Medicare reimbursement policies.

- **Physician Certification of Durable Medical Equipment**

This study will assess how effectively physicians are meeting Medicare expectations that they act as controls against unnecessary use of non-physician services and supplies. This study assesses the physician's role in home health and in completing certificates of medical necessity. Common obstacles and successes in ensuring that physicians perform this important service will be identified.

- **Use of Surgical Modifier**

The OIG will determine whether physicians are improperly using modifier 25 on Medicare Part B claims to increase reimbursements. Modifier 25 is for physicians to claim "Significant, Separately Identifiable Evaluation and Management Service on the Day of Surgery"—the key words being "Separately Identifiable."

KY Controlled Substances Act Changes From 1998 General Assembly

Beginning July 15, 1998:

- Prescriptions for Schedule II controlled substances will be valid for 60 days from date of issue.
- All controlled substance records must be retained for 5 years.
- Pharmacist is authorized to seize a suspect prescription, long enough to verify its validity. Note: This is permissive, not mandatory.
- The law that prohibits obtaining a prescription by deceiving the practitioner has been reworded. Law enforcement personnel expect to be better able to prosecute persons who are merely seeking drugs for non-medical purposes.
- New crimes:
  —Theft, criminal possession or trafficking in prescription blanks
  —Forgery of prescription of legend drug
  —Trafficking or illegal possession of legend drug
  —Possession of forged prescription (legend or controlled substance)

Coming in 1999:

- Written prescriptions for controlled substances must be on paper with security features to minimize photocopying or unauthorized printing.
- All dispensers (including practitioners) will report controlled substances dispensed to a database in the Cabinet for Health Services. Local, state or federal agencies, that already have access to such data by statute, will use the information only for investigative purposes. Neither the data nor any report is a public record.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Grayson

John F DeBow MD — OTO
908 Wallace Ave Ste 201, Leitchfield 42754-1479
1972, Dalhouse U, Canada

Greenup

Jesus P Querubin Jr MD — IM
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1994, U of Louisville

Jefferson

Alexander G Digenis MD — PS
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1988, U of Kentucky

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1991, U of Louisville

Abdul Haq MD — PD
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1988, Dow Med Col, Pakistan

John Austin Jenkins MD — NS
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1991, U of Texas, Galveston

Perry

Geoffrey S Duckworth MD — P
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1965, U of Toronto

Whitley

Tasneem A Khan MD — P
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1990, Dow Med Col, Pakistan

IN-TRAINING

Jefferson

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Angela Joy Crone MD — FP
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Christopher Jay Godshall MD — S
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John Hampton Miller MD — PS
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DEATHS

Mervel V. Hanes, MD
Louisville
1922-1998

Mervel V. Hanes, MD, a retired obstetrician/gynecologist, died May 3, 1998. A 1946 graduate of the University of Louisville School of Medicine, Dr Hanes was a life member of KMA.

Jesse O. VanMeter, Jr, MD
Lexington
1919-1998

Jesse O. VanMeter, Jr, MD, a retired internist, died May 4, 1998. Dr. VanMeter graduated from the University of Virginia School of Medicine in 1944 and was a life member of KMA.

W. Lloyd Adams, MD
Lexington
1906-1998

W. Lloyd Adams, MD, a retired ophthalmologist, died May 7, 1998. A 1946 graduate of Albany Medical College of Union University, Dr Adams was a life member of KMA.

Edward C. Shrader, MD
Louisville
1927-1998

Edward C. Shrader, MD, a retired ophthalmologist, died April 11, 1998. A 1954 graduate of the University of Louisville School of Medicine, Dr Shrader was a life member of KMA.

Richard A. Gould, MD
Louisville
1950-1998

Richard A. Gould, MD, a pediatric urologist, died May 19, 1998. Dr Gould graduated from the University of Kentucky College of Medicine and was an active member of KMA.

WHEN SMOKERS QUIT

Within 20 minutes of smoking that last cigarette, the body begins a series of changes that continues for years.

20 MINUTES
- Blood pressure drops to normal
- Pulse rate drops to normal
- Body temperature of hands and feet increases to normal

8 HOURS
- Carbon monoxide level in blood drops to normal
- Oxygen level in blood increases to normal

24 HOURS
- Chance of heart attack decreases

48 HOURS
- Nerve endings start regrowing
- Ability to smell and taste is enhanced

2 WEEKS to 3 MONTHS
- Circulation improves
- Walking becomes easier
- Lung function increases up to 30 percent

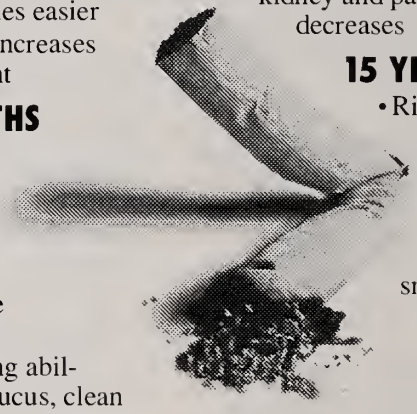
1 to 9 MONTHS
- Coughing, sinus congestion, fatigue, shortness of breath decrease
- Cilia regrow in lungs, increasing ability to handle mucus, clean the lungs, reduce infection
- Body's overall energy increases

1 YEAR
- Excess risk of coronary heart disease is half that of a smoker

5 YEARS
- Lung cancer death rate for average former smoker (one pack a day) decreases by almost half
- Stroke risk is reduced to that of a nonsmoker 5-15 years after quitting
- Risk of cancer of the mouth, throat and esophagus is half that of a smoker's

10 YEARS
- Lung cancer death rate similar to that of nonsmokers
- Precancerous cells are replaced
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decreases

15 YEARS
- Risk of coronary heart disease is that of a nonsmoker



Source: American Cancer Society; Centers for Disease Control and Prevention

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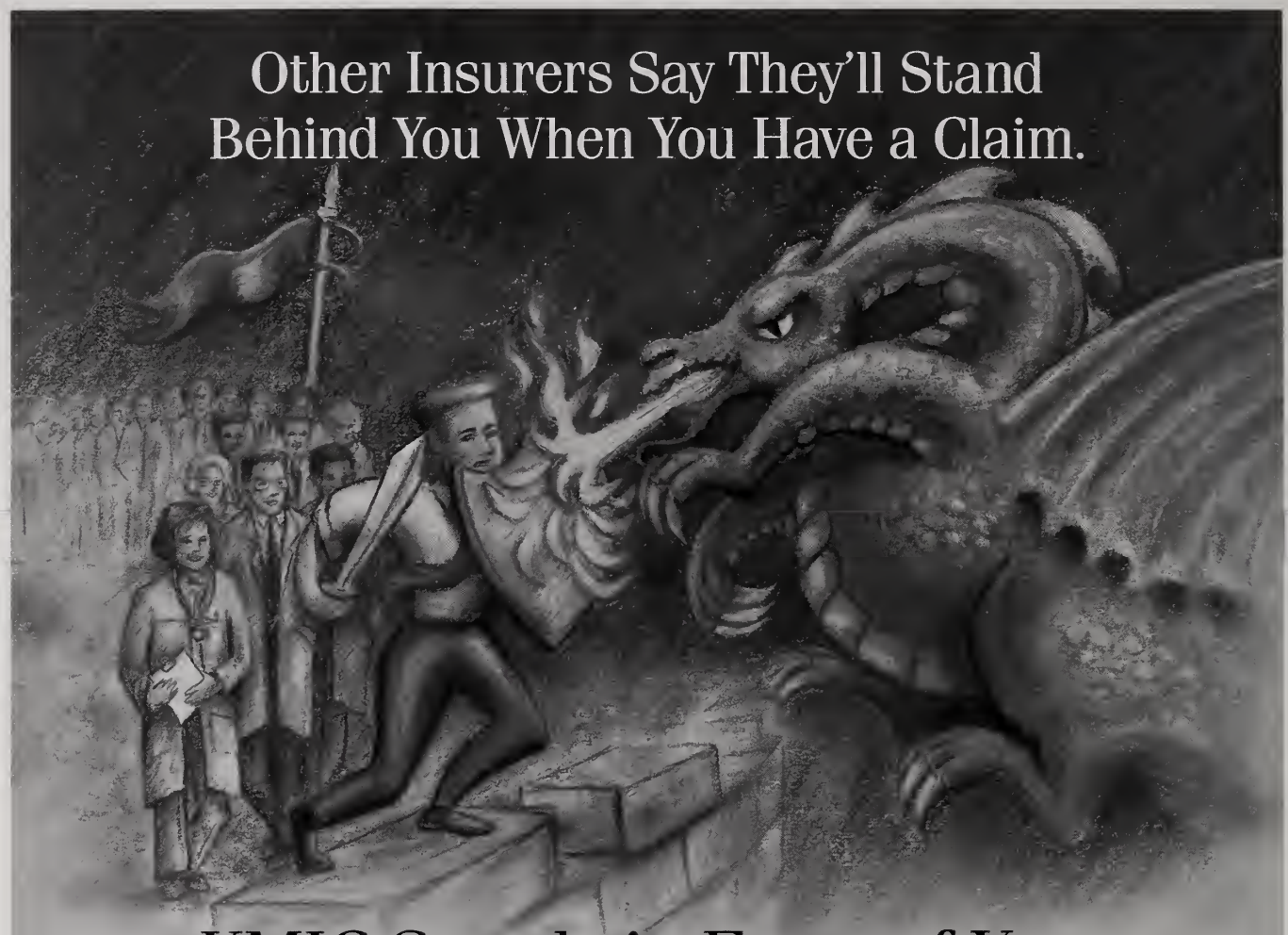


The Team Approach to Healthcare: The Physician's Role

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SCIENTIFIC	Risks of Cerebrovascular Events Related to Open Heart Surgery *Abdulla A. Attum, MD; Roland Girardet, MD; Ronald Barbie, MD; Sam Yared, MD; Dennis Raleigh, MD; Thomas Mathew, MD; William Hymes, MD; Allan Lansing, MD, PhD*	290
EDITORIAL	Securing Privacy — Year 2000 and Beyond *Carolyn D. Burns, MD*	297
ASSOCIATION	*Monitoring Medicine*	287
ANNUAL MEETING	KMA Annual Meeting Preliminary Program	301
	Annual Meeting Exhibit Guide	332
	KEMPAC Political Seminar-Dinner	300
DEPARTMENTS	President's Page	285
	Advertisers' Guide	342
	Alliance Page	298
	Classifieds	340



COVER:
"The Team Approach to Healthcare: The Physician's Role" is the theme of this year's Annual Meeting, scheduled for September 21-24 at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. The 1998 meeting continues KMA's commitment to offering an outstanding educational event featuring numerous sessions on timely medical issues which cut across all specialties. This month's cover introduces a complete preliminary program for this not-to-be-missed event. You will find in these pages a pull-out section containing an abridged schedule of events and maps for your convenience in locating meeting and parking facilities. Highlight your September calendar for Monday the 21st through Thursday the 24th to attend KMA's premier educational event!

Design and artwork by Lee Wade of Eminence, KY.

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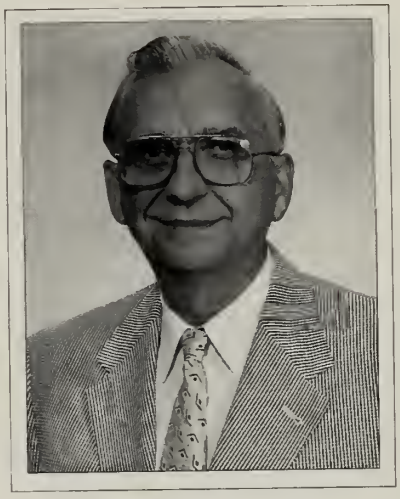
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KMA Future Search



C. Kenneth Peters, MD

During the spring of 1998, KMA undertook several important steps to look at its future, culminating in a two-day retreat in late May. These steps included:

- Launching a member survey to assess KMA services and member priorities;
- Initiating formal dialogue with community opinion leaders about Kentucky health care, their views of Kentucky medicine, and their priorities for the future;
- Assembling background data on non-members, Kentucky community and health care statistics, and national health care trends to assist participants in the late Spring retreat; and
- Convening a unique group of physicians, including both active leadership and newer members from diverse backgrounds, to review the input information and to brainstorm their vision of future goals and priorities.

On May 27 and 28, 1998, 29 physician members of the Kentucky Medical Association, KMA staff, and a representative of the KMA Alliance convened in a unique retreat setting at Shakertown, Kentucky, in order to launch the KMA's first long-range strategic planning process. A strategic vision document provides powerful fuel for shaping an organization's mission, actions, and relationship among its members and the outside world.

The group began its deliberation with the goal of establishing a positive strategic vision of what Kentucky medicine's future could become in the next 5 years. Small groups worked together to imagine the accomplishments KMA could and should achieve by 2003, to identify the barriers to be overcome and the opportunities to be maximized in order to achieve that vision, and to identify suggested next steps for realizing those goals.

The vision is only the first step in organizational action. In the coming months, KMA will need to review, refine, and prioritize the rich array of goals outlined here, assign focus groups or committees to develop action plans more fully and engage members and others in those actions, evaluate funding sources and others resources needed to implement activities, launch pilot initiatives as appropriate, and plan for the thoughtful evaluation of initiatives. It is through this continued energy and commitment that the seeds planted in Shakertown can bear fruit. The major strategic priorities and action steps emerging from that retreat are summarized below.

Recommended Strategic Priorities

Ten major themes and priorities emerged from the Shakertown deliberations. The following summarizes these priorities and provides a brief rationale for their importance to the KMA membership.

Strategic Priority: Maximize physician participation in organized medicine by enhancing services and facilitating better communications to members and targeting non-members for outreach. Work toward a 90% participation rate within 5 years.
— *Rationale: The level of physician engagement directly affects the ability of the KMA to influence activities across all health care policy domains and to shape the future of medicine.*

Strategic Priority: Establish new connections and strengthen existing physician ties with the broader health care community and the public at large.
— *Rationale: The effectiveness of physician leadership across all health care policy domains is directly linked to the ability to communicate with and engage in cooperative activities with the many other organizations and populations who also have a stake in Kentucky health care.*

Strategic Priority: Ensure an effective, year-round governmental

program and seek a balanced partnership with government.
— *Rationale: The legislative and governmental advocacy functions are the top KMA priority among those members surveyed and are also highly ranked by Kentucky opinion leaders. KMA members perceive a continued high level of government involvement in the coming decade and wish to exercise influence and leadership in all health care policy domains.*

Strategic Priority: Position KMA to be a more active leader and advocate in influencing the managed care environment and to serve as a clearinghouse of information for practicing physicians.
— *Rationale: The percentage of health care services affected by managed care practices is expected to continue increasing in the next 5 years, along with the possibility of new delivery systems. These changes must be a top priority for KMA's advocacy and education efforts on behalf of physicians.*

Strategic Priority: Achieve universal access to health care for Kentuckians within 5 years.
— *Rationale: Advocating for the health care of all of the community's citizens is a fundamental role for physicians to play and concern about medically underserved populations continues to rank highly among priorities identified by both Kentucky opinion leaders and KMA members.*

Strategic Priority: Assume a leadership role in raising community awareness of healthy lifestyles, establishing health promotion and disease prevention as the "battle cry" of Kentucky medicine and taking the lead in establishing a better understanding of the role of "complementary" medicine.
— *Rationale: Interviews with Kentucky opinion leaders indicate a strong interest in public health issues and Kentucky's health statistics reflect significant lifestyle-related morbidity and mortality. Moreover, public opinion polls reflect a strong interest in "complementary" medicine. The ability of physicians to provide leadership for the future of Kentucky's health care needs and to remain responsive to patient and community concerns involves all of these critical issues.*

Strategic Priority: Preserve the doctor/patient relationship and emphasize the goal of "putting the patient first" as central to the integrity of medicine.
— *Rationale: The rapid changes in health care delivery have introduced conflicts into the fundamental doctor/patient relationship and protection of this relationship is critical for the practice of the profession.*

Strategic Priority: Foster outcomes-driven quality of care across the state in the next 5 years.
— *Rationale: Physicians are the appropriate leaders in the movement to improve quality of health care and evaluate treatment protocols and these issues affect the basic practice environment of all KMA members.*

Strategic Priority: Take a proactive role in defining and responding to the educational and ethical challenges arising from the new frontiers of medical knowledge.
— *Rationale: Emerging research in genetics and other "new frontier" arenas introduce significant ethical challenges that affect patient care and, thus, physicians.*

Strategic Priority: Continue efforts to achieve tort reform and serve as a resource for medical-legal issues.
— *Rationale: The complex legal environment continues to be a significant practice variable for physicians, and therefore, an advocacy concern for the KMA.*

The primary goal of this initiative was a simple but powerful one: to search for and envision the future of the KMA in the next 5 years. We hoped to invigorate and engage members in a positive dialogue about the possibilities for the future and to generate ideas that would form the basis for an organizational blueprint in the next few years. This report represents the completion of the first stage of the process.

C. Kenneth Peters, MD
KMA President

NEWS FOR KENTUCKY PHYSICIANS

PATIENTS' BILL OF RIGHTS

On Wednesday, July 15, 1998, the Kentucky Medical Association conducted a press conference in the Capitol Rotunda in Frankfort concerning enactment of the Kentucky Patients' Bill of Rights, House Bill 315. Addressing the assembled media groups and large gallery of Kentucky citizens were Representatives Bob Damron (D), Bob DeWeese, MD, (R), and KMA President Ken Peters, MD. In making the following public pronouncement, KMA President Peters urged Congress to extend patient protection provisions to all Kentuckians presently exempted by federal law.

We are here to proudly point to the Kentucky Patients' Bill of Rights, one of the most important laws enacted by the Kentucky General Assembly this year. It is a law Kentucky physicians have worked long and hard for, and I am delighted to tell you it is now in effect and regulations are currently being written to fully implement it.

The co-sponsors of HB 315 are with us today, Representatives Bob Damron of Jessamine County and Bob DeWeese, MD, of Jefferson County.

As physicians, we are foremost concerned about the health of our patients and this legislation provides the opportunity for better care by placing some much needed requirements on HMOs.

The most important of these requirements are these three principles:

1 — The removal of so called Gag Clauses. HMOs will no longer be permitted to try to prevent physicians from discussing all available treatment options with patients.

2 — HMOs will be directed to allow patients to select a physician of their choosing rather than be assigned to a physician. If a patient wishes to go outside the HMO network, they may do so if they choose to pay any additional fees.

3 — If coverage is denied a patient, HMOs will be required to fully explain the decision and to



KMA President Ken Peters, MD, addressed the media group. Waiting to speak, left to right, were State Representatives Bob DeWeese, MD, (R) and Bob Damron (D), co-authors of HB 315.



State Representative DeWeese, always the patient's advocate, was pleased to share in delivering this paramount message to the media.

provide the member with information on how to appeal the decision.

Unfortunately, this legislation will not cover all Kentuckians. The Congress has exempted certain corporations and plans from state regulation. That is the second reason for this news conference. A National Patients' Bill of Rights is being debated in Congress and the KMA fully supports this legislation. We urge Kentucky's lawmakers to get behind it and grant patients' rights to every Kentuckian.

As physicians, we see growing concerns from patients about their health care coverage. Many feel their care is being compromised by insurance company rules and protocols which place greater emphasis on turning profits than providing high-quality patient care.

The legislation being debated in Congress would end gag rules all across the country. It would end HMO secrecy by forcing HMOs to provide members with a detailed and understandable explanation of what the plan does and does not cover. It would allow for an external review if an HMO denies a medical procedure recommended by a physician. *And, it would make HMOs not only accountable but also liable for their decisions.*

Simply put, this legislation coupled with our new law in Kentucky will give patients a greater voice and more control in decisions affecting their health care. That is one reason polls show overwhelming public support for it.

The federal legislation is HR 3605 and S 1890 and we urge everyone to contact their senator and representative to voice support of it.



President Peters stood in the Rotunda of the Capitol in Frankfort to deliver his important pronouncement. In the background is the famous statue of pioneer, scientist, surgeon, Dr Ephraim McDowell, recognized worldwide as the "father of ovariotomy." In 1809, Dr McDowell became the first surgeon ever to cut into the abdominal cavity and remove an ovarian tumor.

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Risks of Cerebrovascular Events Related to Open Heart Surgery

Abdulla A. Attum, MD; Roland Girardet, MD; Ronald Barbie, MD; Sam Yared, MD; Dennis Raleigh, MD; Thomas Mathew, MD; William Hymes, MD; Allan Lansing, MD, PHD

From the Department of Cardiavascular Surgery, Advanced Cardiavascular Institute, Audubon Regianal Medical Center, Lauisville, KY.

Prevention of perioperative cerebrovascular injury in patients undergoing open heart surgery is a serious task for the surgeon, especially as age and severity of atherosclerotic disease increases. The most significant predisposing factors have been identified as existing carotid arterial disease or prior stroke, heavy calcification of the aorta, renal dysfunction, advanced age, and diabetes mellitus.

We have studied a series of 600 open heart patients from 1992 to 1995 for the incidence of perioperative stroke and mortality, evaluating 16 risk factors: heavy calcification of the ascending aorta, asymptomatic carotid disease, insulin-dependent diabetes mellitus, prior CVA, left ventricular function (ejection fraction of 20% or less), age greater than 70, renal dysfunction, transmural myocardial infarction, fluid balance index greater than 2500 ccs, smoking, type of procedure, emergency procedure, non-insulin-dependent diabetes mellitus, cardiopulmonary bypass time, gender, and hypertension. Stroke occurred in 8 patients (1.3%), one of whom died postoperatively. Full or near-full recovery was experienced by 5 patients; 2 patients remained partially dysfunctional at the end of the study period. The operative mortality was 2.0% (12 patients); 10 deaths occurred in hospital and 2 following discharge within 30 days postoperatively. The risk of stroke was 15 times greater in patients over age 70; 16 times greater in older males (≥70 years); 5 times greater in patients with prior stroke or existing (asymptomatic) carotid artery disease; 8 times greater in patients with renal dysfunction; 4 times greater with a positive fluid balance index; and twice greater when cardiopulmonary bypass exceeded 110 minutes. Four of the stroke patients had diabetes mellitus. Two of 9 patients with heavy calcification of the aortic arch suffered cerebrovascular injury. Six or more of the risk factors studied were present in 81 patients; all 8 stroke patients (9.9%) came from this subgroup.

The study suggests the importance of preoperative evaluation of cerebrovascular atherosclerotic disease and the minimal manipulation ("minimal touch" technique) of a calcific aortic arch.

Cerebrovascular injury during or after open heart surgery is a dismaying complication that can severely compromise the patient's postoperative expectations. As open heart procedures are increasingly being undertaken in an older population with advanced atherosclerotic disease, reducing the incidence of stroke is a priority for the surgeon. Age, existing carotid arterial disease or prior stroke, heavy calcification of the aorta, postoperative atrial fibrillation, and diabetes mellitus carry the greatest conditions of risk,[1-6] which ranges from 1.03% to 5.2% in various reports.[2,4,6-12] We have reviewed a series of 600 open-heart patients over a 31-month period to determine perioperative risk factors for cerebrovascular accident and mortality.

Patients and Methods

From October 1992 to May 1995, 600 consecutive open-heart surgical cases were performed by one of the authors (AAA) and evaluated for incidence of perioperative cerebrovascular accident. The data were collected as the patients were admitted and as the events took place. This included age, gender, incidence of diabetes mellitus, hypertension, myocardial infarction, carotid artery disease, previous cerebrovascular accident, renal dysfunction, smoking history, left ventricular ejection fraction, and previous carotid endarterectomy. Surgical data included type of procedure, fluid balance index, duration of cardiopulmonary bypass (CPB), and the intraoperative finding of aortic calcification.

The gender ratio in this series was 2:1, 400 patients were male. One hundred ninety patients were over 70 years of age. The surgical procedure was undertaken as an emergency (ie, the patient

underwent surgery immediately following cardiac catheterization) in 107 cases. All others were performed urgently (within 24 hours) or electively. Types of surgical procedures and outcome are noted in Table 2.

Assessment Technique

The study was designed to assess the incidence of stroke in the conventional practice of cardiac surgery. Carotid artery duplex scanning was used only if there was clinical indication. This included history of previous CVA, history of carotid disease, or presence of carotid bruits. Patients were continually evaluated throughout the hospital stay and immediate convalescent period. Patients who developed neurologic deficits were assessed by clinical examination, electroencephalogram, computerized axial tomography, and duplex carotid scanning.

Operative mortality included deaths of all patients who died prior to hospital discharge, regardless of the time elapsed between surgery and death, and those discharged from hospital who died within 30 days postoperatively.

Surgical Technique

Operations were performed using established techniques appropriate to the various procedures. These did not vary significantly during the 31-month study period. Cardiopulmonary bypass was likewise maintained by standard methods. Anticoagulation was initiated with 2.5 mg/kg weight heparin and monitored every 30 minutes to keep activated clotting time above 400 sec. Heparin was added in 30-50 mg increments as necessary.

Identification of Cerebrovascular Accident

A cerebrovascular accident was considered to be a sudden, major neurological dysfunction lasting more than 24 hours. The word *stroke* is also used to describe this event. Severe neurologic deficits included hemiplegia, hemiparesis, aphasia, ataxia, and visual defects. Embolic strokes were defined as infarctions resulting from a clot that had moved into the cerebral circulation and lodged intravascularly, thus occluding blood flow. Ischemic strokes were considered those resulting from arterial disease.

Statistical Analysis

The potential association of each of the factors listed in Table V with the outcome of cerebrovascular accident was evaluated using a χ^2 test. Odds ratios (ORs) were calculated to measure the degree of association. The results of the analysis are presented in Table V, and will now be discussed.

Table 1. Cerebral Injuries and Timing of Occurrence

Gender/ Age	Distribution Of Injury	Couse	Timing	Recovery
M56	broin stem	embolic	postop	portial
M70	cerebrol	ischemic	postop	expired
M72	cerebrol	ischemic	postop	near-full
M72	cerebral	embolic	postop	partial
M72	cerebral	ischemic	introop	near-full
F76	cerebral	ischemic	introop	full
M72	cerebral	ischemic	introop	near-full
M77	occipital	embolic/ischemic	?	near-full

Table 2. Types of Procedures (coronory ortery bypass grafting only)

Procedure	# pts	# deoths	(%)	# CVA	(%)	Combined %
Elective CABG	397	5	(1.3)	6	(1.5)	2.8
Emergency CABG	89	2	(2.2)	1	(1.1)	3.3
Reoperotive CABG	48	2	(4.2)	1	(2.1)	6.3
TOTAL	534	9**	(1.7)	8**	(1.5)	3.2

** One common potient who hod cerebrovosculor occident and died, which makes the octuol combined mortolity/stroke rote 2.9%

Table 3. Types of Other Procedures

Procedure	# pts	# deoths	(%)	# CVA	(%)	Combined %
AVR	19	0	(0)	0	(0)	0
MVR	19	0	(0)	0	(0)	0
Aortic dissection	5	1	(20.0)	0	(0)	20.0
MV repoir	2	0	(0)	0	(0)	0
Reop single VR	4	0	(0)	0	(0)	0
Single VR, SBE	3	0	(0)	0	(0)	0
TVR	1	0	(0)	0	(0)	0
Double VR, SBE*	2	1	(50.0)	0	(0)	50.0
VSD, post-MI	2	0	(0)	0	(0)	0
LVA + CABG	3	0	(0)	0	(0)	0
Reop MVR + CABG	3	1	(33.3)	0	(0)	33.3
ASD	1	0	(0)	0	(0)	0
MVR + TV annuloplosty	2	0	(0)	0	(0)	0
TOTAL	66	3	(4.5)	0	(0)	4.5

* One of these patients hod prosthetic volve endocorditis.

AVR = oortic valve replacement; MVR = mitrol volve replocement; reop = reoperotion; MV = mitral valve; TVR = tricuspid volve replacement; VR = volve replacement; SBE = subacute bocteriol endocorditis; VSD = ventricular septal defect; MI = myocordiol infarction; LVA = left ventriculor oneurysm; CABG = coronary artery bypass groft; TV = tricuspid volve

Results

A perioperative cerebrovascular accident occurred in eight patients (1.3%). Twelve patients (2.0%) died, one of whom was a postoperative stroke patient. The actual combined mortality/stroke rate was thus 3.2%.

Table 4. Incidence of Perioperative Injury

Disease	# pts	#CVA pts	(%)
Carotid endarterectomy (including 6 pts with history of CVA)	23	0	
Asymptomatic carotid disease	30	2	(6.6)
History of CVA (including 9 pts without CVD)	32	2	(6.3)
TOTAL	85	4	(4.7)

CVA = cerebrovascular accident; CVD = cerebrovascular disease

Timing of Occurrence

Three of the perioperative strokes occurred intraoperatively and four occurred postoperatively (Table 1). In one patient it was difficult to determine whether the stroke had occurred intraoperatively or in the early postoperative period. Of the four postoperative strokes, three occurred on the third postoperative day and one on the ninth day.

Cause

The cause of the cerebrovascular accident was clearly embolic in two patients and ischemic in five patients. In one patient who had only visual symptoms believed to be caused by occipital injury, it was difficult to determine the source of neurologic dysfunction.

Recovery of Neurological Function

One patient had full recovery of neurological function. Profound improvement in four others was considered to be a near-full recovery. At the end of the study period, two patients remained partially dysfunctional after limited improvement.

Timing of Mortality

Ten patients died prior to hospital discharge, one of whom had an early postoperative stroke. Two others had begun recovering at home but died within 30 days postoperatively.

Surgical results were examined in relation to specific risk categories.

- *Emergent Status of the Procedure*

Of the 107 emergency cases, 2 had perioperative stroke (1.9%). Patients who had emergency first-time coronary artery bypass grafting (n = 89) had no higher incidence of neurological complications than the total group. Only one of these 89 patients suffered a stroke (1.1%).

- *Age*

Seven of the 8 postoperative strokes in this series occurred among the 190 patients aged 70 or older (3.7%). Of the 410 patients younger than 70 years, the incidence of cerebrovascular accident was 0.24%. The risk imposed by age, then, was 15 times greater after age 70.

- *Gender*

Seven of the 8 strokes occurred in males (1.8%). Of the 400 males in the series, 109 were age 70 or older, and of this group, 6 had perioperative cerebrovascular accident (5.5%). Only one stroke occurred in the 291 male patients younger than 70 years (0.34%). The risk among males was 16 times greater after age 70

Among the 81 female patients older than 70 years, one patient had perioperative stroke (1.2%), an incidence equal to that of the entire group. None of the 119 female patients younger than 70 years suffered a stroke.

- *Type of Procedure*

Tables 2 and 3 illustrate the incidence of mortality and stroke in the study groups, categorized by type of procedure.

- *Diabetes Mellitus*

One-fourth of the study group had diabetes mellitus (n = 145; 24.2%). The 4 of these patients who had a cerebrovascular injury (2.8%) thus accounted for half the incidence of stroke in the entire series. Thirty-five of the patients were insulin-dependent, 2 of whom developed perioperative cerebrovascular injuries (5.7%). Two of the 110 noninsulin-dependent diabetic patients suffered a stroke (1.8%).

- *Hypertension*

Five of the 303 patients with a history of hypertension had a cerebrovascular accident (1.7%), an incidence rate only slightly higher than the entire group.

- *Smoking*

Of the 135 patients with a history of smoking, 3 had a perioperative stroke (2.2%). Any patient who did not smoke to 10 years prior to surgery was considered a nonsmoker.

- *Left Ventricular Function*

Left ventricular function was severely compromised (ejection fraction ≤20%) in 44 patients, 2 of whom had a perioperative stroke (4.5%). One additional patient died postoperatively. The combined mortality/stroke rate is thus 6.8%.

- *Existing Cerebrovascular Disease*

The series included 85 patients who had a history of carotid artery occlusive disease or prior cerebrovascular accident, or both (Table 4). Four of these patients (4.7%) had perioperative stroke. The incidence of stroke in the remaining patients was 0.78%.

Overall, then, the risk of stroke was increased six times in patients with neurovascular disease.

History of cerebrovascular accident: Two of the 38 patients (5.3%) with a prior stroke developed perioperative injury. Of these 38 patients, 29 had a concomitant history of carotid artery occlusive disease. Both incidents of stroke occurred in this sub-group (6.9%), thus increasing the risk of stroke by five times in such patients. None of the 9 patients with prior stroke without carotid artery occlusive disease suffered perioperative neurological injury.

Carotid artery disease: Asymptomatic carotid artery disease evidenced by bruit and documented by duplex scan had been identified in 30 patients before surgery, 2 of whom (6.7%) had a perioperative stroke. The risk of stroke is thus six times higher when carotid arteriosclerosis is present. Each of these 2 patients had 40% to 60% stenosis in the bilateral carotid arteries, and each had severely fluctuating blood pressure intraoperatively and in the immediate postoperative period. In comparison, 2 other patients with a greater degree of stenosis but who had stable blood pressure suffered no cerebrovascular injury.

History of carotid endarterectomy: Of the 23 patients with previous carotid endarterectomy (2 of whom had unilateral carotid occlusion), none developed cerebrovascular injury.

- *Transmural Myocardial Infarction*

Seventy-three patients underwent surgery within 10 days of acute myocardial infarction, 29 of whom had suffered transmural injury. One of these 29 patients developed an embolic cerebrovascular injury on the fourth postoperative day despite adequate anticoagulation.

- *Renal Dysfunction*

Elevated blood urea nitrogen (BUN) of ≥20 mg was noted in 164 patients in the series, 6 of whom (3.7%) sustained a perioperative cerebrovascular injury. Of these 164 patients, 49 (29.9%) had more than five risk factors for stroke. All six cerebrovascular injuries occurred among these 49 patients. In the remaining patients with BUN of ≤20 mg, the incidence of stroke was 0.46% (2 of 436 patients), and only 32 of whom (7.3%) had more than five risk factors for stroke. The incidence of CVA in patients with renal dysfunction was thus eight times greater.

- *Fluid Balance Index*

The fluid balance index was determined by dividing the total amount of fluid balance delivered intraoperatively by the body surface area. A notable difference was seen among patients who received 2500 cc fluid per square meter body surface (n = 251) compared with those who received less (n = 349). Six of the 251 patients (2.4%) developed perioperative cerebral injury, compared with only two of the remaining 349 patients (0.57%). The stroke-risk differential was thus four times greater in patients receiving the greater quantity of fluid.

- *Duration of Cardiopulmonary Bypass*

Of the 319 patients whose duration of cardiopulmonary bypass was ≤110 minutes, three (0.94%) sustained perioperative stroke. Of the remaining 281 patients, 5 (1.8%) had a cerebrovascular accident, a doubled incident rate.

- *Heavy Calcification of the Aorta*

Nine patients were found to have a heavy calcification of the entire ascending aorta. This group did not include patients with isolated calcific plaque. Two of these 9 patients sustained perioperative stroke, one occurring intraoperatively and one on the third postoperative day. In the latter patient, atrial fibrillation also occurred postoperatively and was concluded to be the precipitating event. The incidence of stroke in these patients was thus 11%.

- *Atrial Fibrillation*

Cerebrovascular injury occurred at the time of atrial fibrillation in two patients. In a third patient, it was difficult to determine whether the injury was embolic or the ischemic result of carotid artery disease.

Table 5. Potential Factors Considered and Univariate Analysis Results

Factor	Incidence Occurrence (%)	of CVA (%)	p-value	OR
Heavily calcified ascending aorta	1.5	11.1	<.01	10.43
Asymptomatic carotid disease	5.0	6.7	<.01	6.71
Insulin-dependent diabetes mellitus	5.8	5.7	<.02	6.83
Prior CVA	6.3	5.3	<.05	5.15
LVEF ≤20%	7.3	4.5	n.s.	4.37
Age ≥70 yrs	31.7	3.7	<.001	11.68
Renal dysfunction	27.3	3.7	<.005	8.24
Transmural MI	4.8	3.4	n.s.	2.88
Fluid balance index ≥2500 cc	41.8	2.4	n.s.	4.25
Smoking	22.5	2.2	n.s.	2.09
Reop CABG	8.0	2.1	n.s.	1.66
Emergency procedure	17.8	1.9	n.s.	1.55
Non-insulin-dependent diabetes mellitus	18.3	1.8	n.s.	0.74
CPB ≥110 min	46.8	1.8	n.s.	1.91
Male gender	66.7	1.8	n.s.	3.54
Hypertension	50.5	1.7	n.s.	1.64

OR = odds ratio; n.s. = not significant at the .05 level; CVA = cerebrovascular accident; LVEF = left ventricular ejection fraction; MI = myocardial infarction; CABG = coronary artery bypass graft; CPB = cardiopulmonary bypass

• *Number of Risk Factors*

Of the 16 risk factors evaluated above, 5 or fewer were documented in 519 of the total patient group (Table 5). None of these patients developed cerebrovascular injury. It was of interest that 4 patients who had a heavily calcified aorta, but who had fewer than 5 other risk factors, developed no neurovascular injuries. The remaining 81 patients had 6 or more risk factors. The 8 stroke patients came from this group, demonstrating a 9.9% incidence of stroke.

Discussion

The debilitating cerebrovascular accident has always been an unfortunate complication of open heart surgery that persistently occurs in 2% to 5% of all cases.[6,12] In recent years, stroke prevention has gained urgency as open heart surgery is increasingly being performed in older patients and those with more advanced atherosclerotic disease.

• *Aortic Calcification*

Our series demonstrated that heavy calcification of the ascending aorta, which is often worsened by age, carried a grave disposition toward perioperative stroke, a finding well supported by other studies.[1,5,9] The finding of a heavily calcified aorta in the operating room is disturbing and can be defeating to the surgeon.

When calcific deposits are embedded within the aortic wall, the simple avoidance of these areas will usually prevent perioperative neurological injury. Aortic manipulation should be kept to a minimum once calcification is identified. When the aorta contains loose, friable, atheromatous material within the lumen, the incidence of subsequent cerebrovascular injury is magnified. In these patients, the atheromatous involvement usually extends into the arch, and any degree of manipulation can dislodge debris that embolizes to the brain. A "no-touch" or "minimum-touch" approach is recommended in these cases.[1,3,5,9,12]

Intraoperative sonography and transesophageal echocardiography will identify aortic thickening and atheromatous formation,[9,13] but will not detect its calcific nature when present. Only upon opening the aorta is the disease seen. Regrettably, intraoperative sonography is not easily available for every cardiac surgical case in private community hospitals, and the expert cardiologist is seldom at hand for a prompt study. In our series, the authors have relied on the patient history, chest x-ray, and occasionally on computerized axial tomography to identify patients with ascending aortic disease.

Once the aortic calcification is identified, the plan of the operation is changed. The femoral artery can be an alternative arterial cannulation site if it is soft and free of calcification; this was successful in only 2 of the 9 patients without sequela. One must remember that retrograde flow through a diseased descending aorta could lead to cerebral embolization.

For aortic cannulation, gentle palpation from the aortic root to the mid-aortic arch seeks to reveal a soft area. It is imperative that this be done with systolic blood pressure in the range 100 mm Hg. Higher pressures make assessment of the aorta difficult or impossible.

In all cases in this series, aortic cross-clamping and blood cardioplegia were used. Cardioplegia is induced through a retrograde cannula, using the internal thoracic artery (unilateral or bilateral). The aortic clamp is applied once and is not disturbed until the procedure is completed. Both the distal and proximal anastomoses of vein grafts are performed while the aorta is clamped.

The segment of aorta immediately above the aortic valve is usually spared calcification and may accommodate one or two proximal anastomoses. Remaining grafts may be anastomosed end-to-side to other saphenous vein grafts. Brachycephalic artery can be used for proximal anastomosis. Removal of air from the ascending aorta is accomplished through the final proximal anastomosis before it is completed. The use of gastro-epiploic artery can be an alternative; however, the size of this vessel in the elderly can be a disappointing experience.

These techniques were successful in our series. Cerebrovascular injury occurred in only one of the 9 patients with severe calcific disease, who subsequently had near-full recovery of neurological function. In the second patient, stroke occurred following an episode of atrial fibrillation. None of these patients died. Replacement of the entire ascending aorta is advocated by some surgeons,[3,9] but in patients with multiple risk factors, a prolonged operation increases the risk of mortality and morbidity.

• *Carotid Artery Disease*

A dilemma facing the cardiovascular surgeon is the management of patients with combined cardiovascular and carotid artery occlusive disease. Patients with a history of cerebrovascular accident without carotid artery occlusive disease are still at high risk of developing neurological injury in the operating room and in the immediate postoperative period.[10,14]

Carotid artery occlusive disease presents the greater dilemma. The emergent cardiac status of

the patient may not allow a comprehensive evaluation preoperatively. The authors' policy is to stage the surgical procedures and treat the more symptomatic disease first. The mortality of simultaneous carotid and cardiac operations has been reported as high as 13%[9] with a permanent stroke rate of 3.0%.[14] Maintaining stable blood pressure and a higher hematocrit, reducing hemodilution, and using a hemoconcentrator on cardiopulmonary bypass is of much value inpatients with concomitant carotid artery disease. Additionally, it is beneficial to reduce the nonpulsatile period of cardiopulmonary bypass time by allowing the heart to eject when good contractility is observed. The use of concentrated albumin solutions in cardiopulmonary bypass did not reduce the incidence of cerebrovascular injury in these patients.

- *Transmural Myocardial Infarction and Poor Left Ventricular Function*

Our series showed an increased incidence of cerebrovascular accident in patients undergoing myocardial revascularization after a transmural infarction. Our routine practice is to anticoagulate all such patients who have coronary artery bypass grafting. In one patient in this study, a stroke occurred despite adequate anticoagulation. Likewise, patients with poor left ventricular function ordinarily do not require routine anticoagulation except in cases of atrial arrhythmia. The incidence of postoperative atrial fibrillation has been associated with a sharply increased risk of stroke.[2,14]

Minimally invasive direct coronary artery bypass (MIDCAB) is a newly emerging technology. MIDCAB may reduce the hospital stay, cut costs, and reduce mortality and morbidity. Elimination of cardiopulmonary bypass may reduce the incidence of cerebrovascular accidents.

Another newly emerging technology is the transmural myocardial revascularization (TMR). This procedure is still in the experimental stage and if successful in relieving angina would be another alternative for patients who are at high risk for cerebrovascular accidents.

Conclusion

Our series showed that cerebrovascular accident is related to increased number of risk factors; the highest incidence is among patients with heavily calcified aorta, asymptomatic carotid disease, insulin-dependent diabetes, renal dysfunction, age, and prior cerebrovascular accident. There is a fivefold increase in perioperative stroke in patients with asymptomatic carotid artery disease. Evaluating cerebrovascular status in patients with cerebrovascular disease prior to elective open-heart procedures and treating the more urgent condition first may reduce the incidence of CVA. When extensive aortic calcification is encountered intraoperatively, the goal of complete revascularization should be modified to allow only minimal manipulation of the aorta. Replacement of the ascending aorta in these patients will not eliminate or reduce the risk factors for CVA. Patients who undergo myocardial revascularization following transmural myocardial infarction will benefit from anticoagulation. Patients with fewer number of risk factors are at a low risk of developing perioperative cerebrovascular accidents.

References

1. Davilla-Roman VG, Barzilai B, Wareing TH, et al. Intraoperative ultrasonographic evaluation of the ascending aorta in 100 consecutive patients undergoing cardiac surgery. *Circulation.* 1991;84[suppl III]:47-53.
2. Creswell LL, Schuessler RB, Rosenbloom M, Cox JL. Hazards of postoperative atrial arrhythmias. *Ann Thorac Surg.* 1993; 56:539-549.
3. Wareing TH, Davila-Roma VG, Barzilai B, et al. Management of the severely atherosclerotic ascending aorta during cardiac operations. *J Thorac Cardiovasc Surg.* 1992;103:453-462.
4. Ricotta JJ, Faggioli GL, Castilone A, et al. Risk factors for stroke after cardiac surgery; Buffalo Cardiac-Cerebral Study Group. *J Vasc Surg.* 1995;21:359-364.
5. Mills NL, Everson CT. Atherosclerosis of the ascending aorta and coronary artery bypass. *J Thorac Cardiovasc Surg.* 1991; 102:546-553.
6. Reed GL III, Singer DE, Picard EH, DeSanctis RW. Stroke following coronary artery bypass surgery. *N Engl J Med.* 1988; 319:1246-1250.
7. Rorick MB, Furlan AJ. Risk of cardiac surgery in patients with prior stroke. *Neurology.* 1990;40:835-837.
8. Vermeulen FEE, Hamerlijnck RPHM, Defauw JJAM, Ernst SMPG. Synchronous operation for ischemic cardiac and cerebrovascular disease; early results and long-term follow-up. *Ann Thorac Surg.* 1992;53:381-390.
9 Wareing TH, Davila-Roman VG, Daily BB, et al. Strategy for the reduction of stroke incidence in cardiac surgical patients. *Ann Thorac Surg.* 1993;55:1400-1408.
10. Berens ES, Kouchoukos NT, Murphy SF, Wareing TH. Preoperative carotid artery screening in elderly patients undergoing cardiac surgery. *J Vasc Surg.* 1992;15:313-323.
11. Horrow JC, Van Riper DF, Strong MD, et al. Homeostatic effects of transexamic acid and desmopressin during cardiac surgery. *Circulation.* 1991;84:2063-2070.
12. Mills SA. Cerebral injury and cardiac operations. *Ann Thorac Surg.* 1993;56:S86-S91.
13. Marschall K, Kanchuger M, Kessler BE, et al. Superiority of transesophageal echocardiography in detecting aortic arch atheromatous disease; identification of patients at increased risk of stroke during cardiac surgery. *J Cardiothorac Vasc Anesth.* 1994;8:5-13.
14. Wong DHW. Perioperative stroke; Part II; cardiac surgery and cardiogenic embolic stroke. *Can J Anaesth.* 1991;38:471-488.

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"As we move toward the so-called lifetime computerized medical record, we must be leery of instituting systems where breaches in security and acquisition of private information can occur."

The outward and obvious signs of our level of technology are evident every day in our telephones, fax machines, voice activated equipment, and computers. Who among us does not use these in some manner? These systems are very often a bit intimidating to someone such as myself and surely to many of you. I am genuinely amazed at the quantity of information that can be generated, stored, and dispatched in a matter of minutes. Although these technologies have certainly made our lives at work and home much easier, I am concerned about our dependency on these and the inability to protect confidentiality. In the era of the "computerized medical record" this may become our greatest threat.

Case in point . . . I recently had a very difficult case which ultimately involved an outside consultant. This was one of those veritable diagnostic dilemmas that the surgeon and I agreed should be sent for another opinion. I completed all pertinent studies in-house and quickly dispatched the case report and slides to my consultative Olympian. Interestingly, one week later I received a phone call from another physician (not directly involved with the patient's care) who wished to discuss the consultant's diagnosis. I mentioned that I had not received the outside report to date and, therefore, was unaware of his opinion. To my surprise I was subsequently faxed a copy of a fax which represented the consultant's letter to me. In other words, someone else somewhere had obtained a copy of our private correspondence which I had not yet received. This, in turn, had been shared with another physician. Not only was I stunned, but rather upset.

All-in-all, no harm was done to the patient and he received excellent care. This incident, however, has made me keenly aware of the potential violation of patient and physician privacy.

As we move toward the so-called lifetime computerized medical record, we must be leery of instituting systems where breaches in security and acquisition of private information can occur. If it is so easy for someone outside an office to acquire a copy of a private letter or report from an institution that is out-of-state, just imagine how simple it might be to access patient or personal files via modem!

One could extrapolate from this that even insurance carriers or personnel outside the medical community could potentially intercept private material. And doesn't this open whole new doors in the medico-legal arena?

With our entry into the 21st century, we should raise serious questions about our new technologies. Physicians need to be directly involved in these processes so safeguards remain in place. Part of our job must be to vigilantly secure patient confidentiality.

Carolyn D. Burns, MD

What Do They Do at That Fall Meeting Anyway?



Jan Crase

The KMA Alliance will be having a fall board and membership meeting, September 21 and 22, during the same time as the KMA Annual Meeting. These meetings and workshops are open to all who wish to attend. The educational workshops should be very interesting and informative.

Membership — A membership workshop will be conducted by Liz Kagan, AMAA Treasurer, who is a practicing attorney that still finds time to be active in the Alliance on a local, state and national level. She is a fine example of tomorrow's professional spouse member.

AMA Education and Research Foundation — Vicky Borders, KMA Alliance Vice President, will be conducting this workshop. Vicky has been involved with raising funds for AMA/ERF in her own county of Boyd which has set records for many years and has received much national recognition and attention for the wonderful job they do. Vicky has some unique ideas ready to present. This should be an interesting workshop!

SMART — (Students Made Aware Reject Tobacco) — Audrey Carter, KMA Alliance Vice President of Health Promotions, has worked with the SMART program in Jefferson County for the last 2 years teaching over 200 programs to schools, health department educators, pediatric residents of Children's Hospital and the medical students at U of L. This has become an extremely popular program. It is a tobacco prevention program for middle school students, using upbeat and pointed slides, that looks at tobacco and how it affects young people today as well as later in life. It is a frank, straightforward program developed by KY Alliance members Mary Gus Smith and Ginny Luftman of Fayette County. This program is one of the best of its kind. Be sure to attend.

Growing Healthy — Carolyn Daley, President-Elect, will have a representative speaker for the Growing Healthy Program at the Monday KMAA luncheon, 11:30 am. Growing Healthy is a permanent health education program for grades K-6 which is currently being used in the Hazard city schools and is sponsored by the Perry County Medical Association Alliance. The program is in every city school in Knoxville as well as Memphis, Tennessee, and in approximately 11,000 schools throughout the country. It is a wonderful program which enhances decision-making skills and improves self-esteem in the students. Come learn about this new innovative program and see if you might be interested in promoting this in your county.

Legislative Workshop — Our own State Representative, Dr Bob DeWeese, will be conducting this workshop and it should be most informative. Dr Bob will be giving us "Back to Basics" training and help us with "combat readiness." We can't fight a war without an army that has received some "basic training" and is "combat ready." This workshop should help us all be better prepared to deal with the legislative process.

Come and See for Yourself!

(Everyone is welcome)

The Alliance Fall Meeting schedule is as follows:

Monday, September 21, 1998 — Seneca-Iroquois Rooms

8:30	Registration
8:00	Planning Committee meeting
9:00	Legislative Committee meeting
9:30	Health Promotions Committee meeting
10:00	AMA Foundation Committee meeting
10:30	Membership workshop — Liz Kagan
11:30	Lunch & Growing Healthy workshop
1:00	AMA Foundation workshop
1:30	S.M.A.R.T. workshop
2:30	Membership Committee meeting
3:00	Finance Committee meeting
3:15	By-laws Committee meeting

Everyone is encouraged to attend the KEMPAC reception & dinner.
This is a reminder to join KEMPAC if you have not already done so.

Tuesday, September 22, 1998 — Conference Theater

8:30	Registration
7:30	Executive Committee meeting
8:30-12:00	KMAA Board meeting
9:00	Guest speaker & Legislative workshop
12:00	Lunch & style show (Seneca — Iroquois Rooms)

Come join us, your input is always welcome! Please encourage your spouse to attend any and all of these Alliance activities.

Jan Crase
KMAA President

MARK YOUR CALENDAR NOW TO ATTEND THE

36TH ANNUAL

KEMPAC POLITICAL SEMINAR-DINNER

DATE: Monday, September 21, 1998

TIME: 6:00 PM EDT — Reception
7:00 PM EDT — Dinner and Program

LOCATION: Hyatt Regency Ballroom
Hyatt Regency Hotel
Louisville, Kentucky

TICKETS ARE NOW ON SALE AND CAN BE PURCHASED FROM THE KEMPAC OFFICE FOR $30 EACH. MAKE CHECKS PAYABLE TO KEMPAC AND MAIL ALONG WITH FORM BELOW TO:

KEMPAC

4965 US HWY 42, SUITE 2000

LOUISVILLE, KY 40222

Name_____

Address_____

_____

Amount Enclosed_____ No. Of Tickets_____

1998
PRELIMINARY PROGRAM



The Team Approach to Healthcare:

The Physician's Role



Contents

Official Call 303
KMA Officers for 1997-98 304-306
Journal Editors 307
District Trustee Map 308
Elections 310
Abridged Schedule of Annual Meeting Events 311*
Map of Hyatt Regency Hotel 312*
Map of Downtown Louisville 313*
Parking Map 314*
KMA Delegates 315
Reference Committee Activity 317
Special Features 319
Milton Board, MD, 1870-1950 320
Introducing the Guest Speakers 322
General Sessions Learning Objectives 324
Scientific Program 326
Exhibit Hall Floor Plan 332
Exhibitor Directory 333
Technical Exhibits 334

**For your convenience these pages are in a special pull-out section.*

Official Call KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

The Annual Meeting of KMA will convene on Monday, Tuesday, Wednesday, and Thursday, September 21, 22, 23, and 24, at the Hyatt Regency Hotel and Commonwealth Convention Center, Louisville. The first General Session will be called to order at 8:30 AM, Tuesday.

The House of Delegates

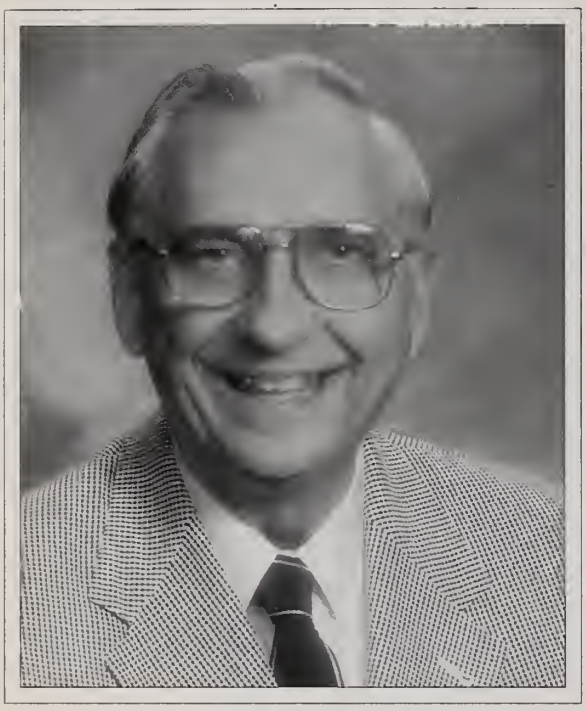
The first regular meeting of the House of Delegates will convene at 10:00 AM, Monday, September 21, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Wednesday, September 23, in the Regency Ballroom.

Registration

The Registration Desk, located outside the Regency Ballroom, 2nd Floor of the Hyatt Hotel, will be open for Delegates at 8:30 AM, Monday, September 21, and at 6:00 PM, Wednesday, September 23. General registration will be held from 7:30 AM until 5:00 PM on Tuesday and 7:30 AM to 4:00 PM on Wednesday, at the General Registration Desk located in the lobby of the Commonwealth Convention Center.



KMA Officers 1997-98

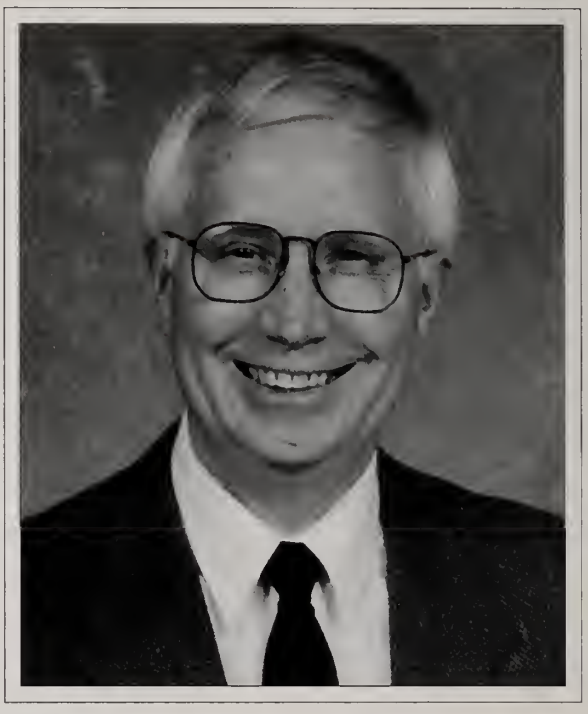


C. Kenneth Peters, MD
KMA President

On Wednesday, September 23, C. Kenneth Peters, MD, Louisville, will pass the mantle of leadership of the Kentucky Medical Association to Donald R. Stephens, MD, Cynthiana.

Dr Peters, a highly regarded family physician practicing in Jeffersontown, has demonstrated his commitment to all Kentucky physicians throughout his year as President, and during the many years he has been involved in organized medicine. He is a Past President of the Jefferson County Medical Society and has served KMA as Vice Speaker and Speaker of the House, KEMPAC Chair, on the State Legislative Committee for 18 years, and as a KMA Delegate for 21 years. His commitment continues with current service on the KMA Membership Task Force and the PLI, Public Education, Scientific Program, and Legislative Quick Action Committees.

Dr Peters' performance as President of KMA has been exemplary as he has championed the causes of the medical community in Kentucky.



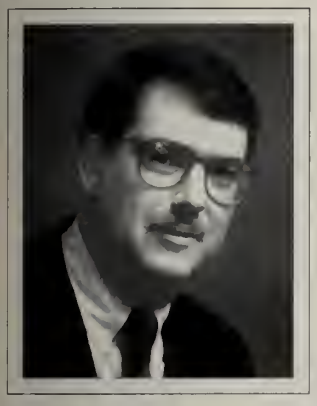
Donald R. Stephens, MD
President-Elect

Donald R. Stephens, MD, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 23.

An esteemed family physician practicing in Cynthiana, Dr Stephens served 23 years as 9th District KMA Delegate, several years as an Alternate Trustee, then three terms as Trustee. He Chaired the KMA Board of Trustees for two terms beginning in 1994, prior to his election as Vice President for 1995-96. Current commitments include service on the PLI, Scientific Program, and Legislative Quick Action Committees.

Dr Stephens is a diplomate of the American Board of Family Practice, a charter fellow of the American Academy of Family Physicians, a member of numerous professional associations, and serves on the Associate Faculty at the University of Kentucky.

A native Kentuckian, Dr Stephens is a 1956 graduate of the University of Kentucky and a 1960 graduate of the University of Louisville School of Medicine. Following a rotating internship at St. Elizabeth Hospital in Dayton, Ohio, he began his Cynthiana practice in 1961. That practice has continued to the present, with the exception of 1967-69 when he served his country in the US Army, including a one year tour in Vietnam.



Vice President
Harry W. Carloss, MD
Paducah

Dr Carloss, an internist practicing in Paducah, served as 1st District KMA Delegate for 13 years, as a Trustee for 5 years, and as Vice Chair and Chair of the Board of Trustees prior to his election as Vice President. He currently serves on the Cancer, Professional Liability Insurance, and Public Education Committees, as well as the Physician Advisory Committee to Health Kentucky. A 1975 graduate of the University of Louisville School of Medicine, Dr Carloss is a fellow of the American College of Physicians and the Royal Society of Medicine.



Secretary-Treasurer
William P. VonderHaar, MD
Louisville

A family physician practicing in Louisville, Dr VonderHaar was elected Secretary-Treasurer in 1990, served as KEMPAC Chair in 1994 and again in 1996, and currently serves on the Legislative Quick Action, Continuing Medical Education, Professional Liability Insurance, and Awards Committees. Dr VonderHaar was recipient of KMA's Educational Achievement Award in 1988 and is a past honoree of the Citizen Doctor of the Year Award presented by the Kentucky Academy of Family Physicians.



Speaker of the House
John W. McClellan, Jr, MD
Henderson

Dr McClellan, a family physician, served KMA for several years in the House of Delegates and as 2nd District Alternate Trustee from 1982 until 1988 when he was elected Trustee. In 1994, he was elected Vice Speaker, a position he held until 1996 when he was elevated to Speaker. A 1960 graduate of the University of Louisville School of Medicine, Dr McClellan is a past President of the Henderson County Medical Society.



Vice Speaker of the House
Thomas K. Slabaugh, MD
Lexington

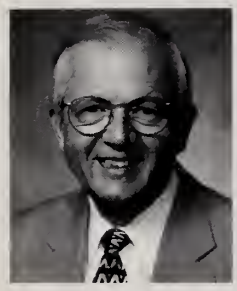
In 1996, Dr Slabaugh, a Lexington urologist, was elected to a two-year term as Vice Speaker. He has served as a KMA Delegate for Fayette County for several years and is a Past President of the Fayette County Medical Society. He currently serves as Chair of KMA's CME Committee. Dr Slabaugh earned his medical degree from the University of Virginia in 1973.



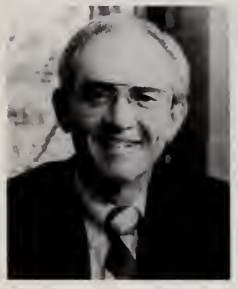
KMA Delegates to AMA



Donald C. Barton, MD
Corbin
Dr Barton, a family physician, was elected AMA Delegate in 1984. A past Chair of the KMA Board of Trustees and past KMA President, his extensive service includes KMA Delegate; AMA Alternate Delegate; Vice Chair, Southeastern Delegation, AMA; past Chair of KEMPAC Board; and 15th District KMA Trustee for several years. Dr Barton chairs the Committee on National Legislative Activities and the Physician Advisory Committee to Health Kentucky. He also serves on the Awards and State Legislative Activities Committees. In 1993, Dr Barton received KMA's Distinguished Service Award.



Wally O. Montgomery, MD
Paducah
Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chair, and on numerous committees. He chairs the State Legislative, Legislative Quick Action, and PLI Committees and is a member of the Awards Committee. Dr Montgomery is a past KY Governor and past President of the KY Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery. In 1990 he was recipient of KMA's Distinguished Service Award.



Robert R. Goodin, MD
Louisville
Dr Goodin, a cardiologist, was elected AMA Alternate Delegate in 1986 and Delegate in 1990. In 1996, he became a member of the AMA Council on Medical Education. He has served KMA as President-Elect and President, and currently chairs the Interspecialty Council and Physician Workforce Committees. Dr Goodin also serves on the CME and National Legislative Activities Committees.



Ardis D. Hoven, MD
Lexington
Dr Hoven, an infectious disease specialist, was elected AMA Delegate in 1993, following service as an AMA Alternate Delegate from 1989-93. Past service to KMA includes President-Elect and President. She currently chairs the KMA Membership Task Force and is a member of the Community and Rural Health Committee and Subcommittee on Domestic Violence. Dr Hoven recently was elected to the AMA Council on Medical Service.



Donald J. Swikert, MD
Florence
Dr Swikert, a family physician, was elected AMA Delegate in 1994. He served as AMA Alternate Delegate from 1989-94. Dr Swikert was the founding Chair of the Young Physicians Steering Committee, a KMA Alternate Trustee in 1985-88, and currently serves on Awards, Medicaid Managed Care, and Community and Rural Health Committees. Dr Swikert is a Past President of the Northern Kentucky Medical Society and the Kentucky Academy of Family Physicians.

Journal Editors



A. Evan Overstreet, MD, Editor
Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.



Kimberly A. Alumbaugh, MD
Louisville

Dr Alumbaugh, an obstetrician-gynecologist, joined *The Journal* in 1996 as an Assistant Editor. A 1986 graduate of the University of Missouri at Columbia, Dr Alumbaugh is active in several professional organizations, including the American College of Obstetrics and Gynecology.



Carolyn D. Burns, MD
Louisville

Dr Burns, a pathologist, joined *The Journal* in 1995 as an Assistant Editor. A 1986 graduate of the University of Missouri School of Medicine, Dr Burns is an Associate Clinical Professor in the University of Louisville Department of Pathology and a member of several professional organizations including the American Society of Clinical Pathologists, College of American Pathologists, and the International Academy of Pathology.



Daniel P. Garcia, MD
Louisville

Dr Garcia joined *The Journal* in early 1998 as an Assistant Editor. An allergist, he is a 1973 graduate of the University of Louisville School of Medicine. Dr Garcia is a diplomate of the American Board of Allergy, Asthma and Clinical Immunology, a member of several professional organizations, and extensively involved in community and philanthropic endeavors.



Stephen Z. Smith, MD
Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of several professional organizations including the American Academy of Dermatology.



Jaroslav P. Stulc, MD
Madisonville

Dr Stulc, a surgeon, joined *The Journal* in 1994 as an Assistant Editor. A 1973 graduate of the University of Iowa College of Medicine, Dr Stulc is affiliated with the Trover Clinic in Madisonville, Kentucky. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and an instructor for Advanced Trauma Life Support (ATLS). In addition to his duties at Trover Clinic, Dr Stulc serves as Commander, United States Naval Reserve Medical Corp-Active Duty.



Daniel W. Varga, MD
Louisville

Dr Varga joined *The Journal* in 1990 as Scientific Editor. An internist, he is a 1984 graduate of the University of Louisville School of Medicine. He serves as KMA's 5th District Trustee, has served as Alternate Delegate and Delegate to the KMA House of Delegates, is a Past President of the Jefferson County Medical Society, and is a member of the KMA Medicaid Managed Care Committee.



KMA District Trustees



Robert C. Hughes, MD
First District





Daniel W. Varga, MD
Fifth District





Donald R. Neel, MD
Second District





John T. Burch, MD
Sixth District





Charles R. Dodds, MD
Third District





John M. Patterson, MD
Seventh District





Eugene H. Shively, MD
Fourth District





Thomas E. Bunnell, MD
Eighth District





J. Gregory Cooper, MD
Ninth District





Kenneth R. Hauswald, MD
Thirteenth District





Andrew R. Pulito, MD
Tenth District





E. D. Roberts, MD
Fourteenth District





Richard A. Stone, MD
Eleventh District

(Photo not available)



Meredith J. Evans, MD
Fifteenth District





Donald E. Brown, MD
Twelfth District





Nominating Committee to Meet Monday, September 21

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates on Monday, September 21, 1998, in the Regency Ballroom of the Hyatt Regency Hotel, Louisville. Any KMA member may confer with the committee during this meeting.

The report of the Nominating Committee will be posted in the general sessions hall in the Commonwealth Convention Center at the conclusion of the first general session, Tuesday morning, September 22.

Nominations may be made from the floor during the second meeting of the House of Delegates on Wednesday evening, September 23. The House will vote on the nominees at this meeting.

Members of the Nominating Committee are: Susan M Berberich, MD, Louisville, Chair; Lucian Y. Moreman, MD, Elizabethtown; Mary Jo Ratliff, MD, Pikeville; Dennis B. Kelly, MD, Lexington; and John S. Cave, MD, Henderson.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office to the attention of the Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1998-99 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 23. Officers to be elected from the state-at-large are:

Office	Term
President-Elect	1 Year
Vice President	1 Year
Speaker, House of Delegates	3 Years
*John W. McClellan, Jr, MD, Henderson	
Vice Speaker, House of Delegates	3 Years
*Thomas K. Slabaugh, MD, Lexington	
Delegates to AMA	2 Years
*Wally O. Montgomery, MD, Paducah	
*Robert R. Goodin, MD, Louisville	
*Donald J. Swikert, MD, Florence	
Alternate Delegates to the AMA	2 Years
*Bob M. DeWeese, MD, Louisville	
*Preston P. Nunnelley, MD, Lexington	
*William B. Monnig, MD, Edgewood	

*Incumbent

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 23, 1998. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House, on Monday, September 21.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 22. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 23. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: 1st District (incumbent, Robert C. Hughes, MD, Murray); 3rd District (incumbent, C.R. Dodds, MD, Earlington); 4th District (incumbent, Eugene H. Shively, MD, Campbellsville); 12th District (incumbent, Donald E. Brown, MD, Somerset); and 14th District (incumbent, E. D. Roberts, MD, Pikeville). Trustees in the 1st, 3rd, 4th and 12th Districts are elegible for reelection; while the Trustee in the 14th has served two consecutive terms and is not eligible for reelection.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 3rd District, Uday V. Dave, MD, Madisonville; 4th District, Brian F. Wells, MD, Campbellsville; 12th District, David C. Liebschutz, MD, Danville; and 14th District, Baretta R. Casey, MD, Pikeville.

Alternate Trustees in the 3rd, 4th, 12th, and 14th Districts are eligible for reelection. In addition, there is a vacancy in the 1st District and an Alternate Trustee needs to be elected for a three-year term.

Abridged Schedule of Annual Meeting Events

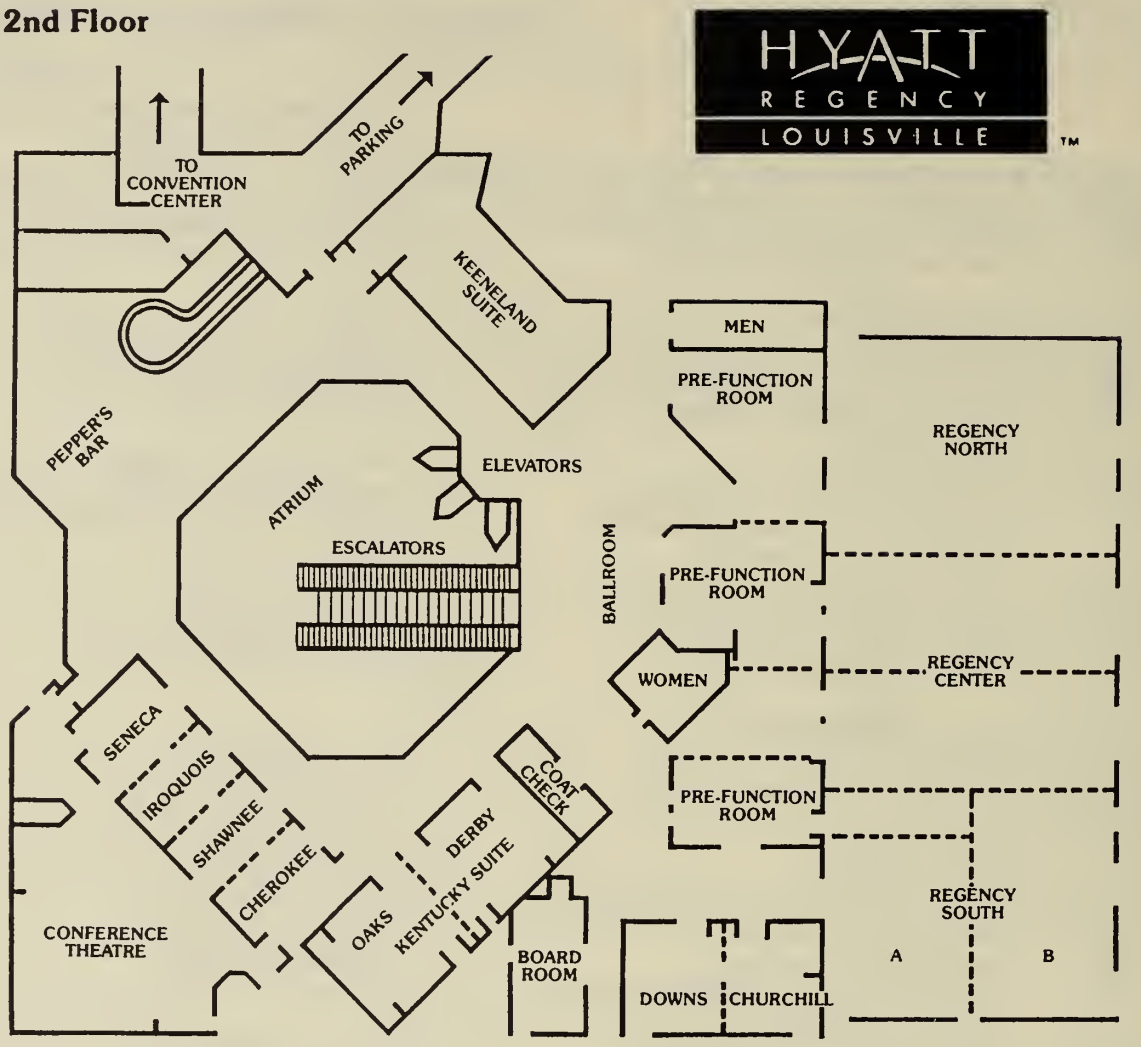
CC = Commonwealth Convention Center
HH = Hyatt Regency Hotel

	Sunday, September 20	
9:00 AM	KMA Executive Committee Meeting	Derby Room - HH
12:00 PM	KMA Board of Trustees Meeting & Lunch	Regency Ballroom South - HH
6:00 PM	KMA Board of Trustees Dinner	Regency North - HH
	Monday, September 21	
8:00-5:00 PM	Alliance Meetings	Seneca/Iroquois Rooms - HH
8:30 AM	Registration for House of Delegates	Outside Regency Ballroom - HH
8:30 AM	Continental Breakfast for House of Delegates hosted by JCMS	Regency Ballroom Foyer - HH
8:30 AM	Alliance Registration	Outside Regency Ballroom - HH
10:00 AM	First Meeting, KMA House of Delegates	Regency Ballroom North & Center - HH
11:45 AM	Trustee Districts Nominating Committees/ KMA Nominating Committee	Regency Ballroom North & Center - HH
11:45 AM	Rural Caucus/Luncheon	Keeneland Suite - HH
12:00 NOON	Reference Committee Chair Luncheon	Derby Room - HH
1:00 PM	Reference Committee Meetings	Various Meeting Rooms - HH
6:00 PM	KEMPAC Reception & Dinner	Regency Ballroom - HH
	Tuesday, September 22	
7:00 AM	KEMPAC Board Breakfast Meeting	Keeneland Suite - HH
7:00-9:00 AM	Reference Committee Report Signing	Churchill Downs - HH
7:30 AM	Registration	Registration Area - CC
8:30 AM	Alliance Registration	Outside Regency Ballroom - HH
8:15-9:00 AM	Free Coffee & Danish	Exhibit Hall - CC
8:30 AM	Opening Ceremonies, First Scientific Session	General Sessions Area - CC
8:30 AM	Alliance Fall Board Meeting	Conference Theatre - HH
12:00 NOON	Young Physicians Luncheon	Keeneland Suite - HH
12:00 NOON	Executive Committee & Reference Committee Chair Luncheon Meeting	Kentucky Suite - HH
12:00 NOON	AMA Contract Review Seminar	Meeting Room 117 - CC
12:00 PM	Alliance Luncheon/Fashion Show	Seneca/Iroquois - HH
1:00 PM	MSS/RPS Annual Meeting	Meeting Room 104 - CC
1:30 PM	Specialty Group Sessions...10 Specialty Groups will meet simultaneously at this time.	Various Meeting Rooms - CC (Programs begin on page 326)
2:00 PM	AMA Contract Review Seminar	Meeting Room 117 - CC
	Wednesday, September 23	
7:30 AM	Registration	Registration Area - CC
8:15-9:00 AM	Free Coffee & Danish	Exhibit Hall - CC
8:30 AM	Second Scientific Session	General Sessions Area - CC
11:50 AM	President's Installation/Awards Luncheon	Regency Ballroom North & Center - HH
2:15 PM	Specialty Group Sessions...10 Specialty Groups will meet simultaneously at this time.	Various Meeting Rooms - CC (Programs begin on page 329)
3:00 PM	KMA Board of Trustees Meeting	Regency South - HH
5:00 PM	Rural Caucus Meeting/Dinner	Keeneland Suite - HH
6:00 PM	Registration for House of Delegates	Outside Regency Ballroom - HH
7:00 PM	Second Meeting, KMA House of Delegates	Regency Ballroom North & Center - HH
	Thursday, September 24	
7:30 AM	KMA Board of Trustees Breakfast Meeting	Regency South A - HH
9:00 AM	Domestic Violence Seminar	Regency Center - HH

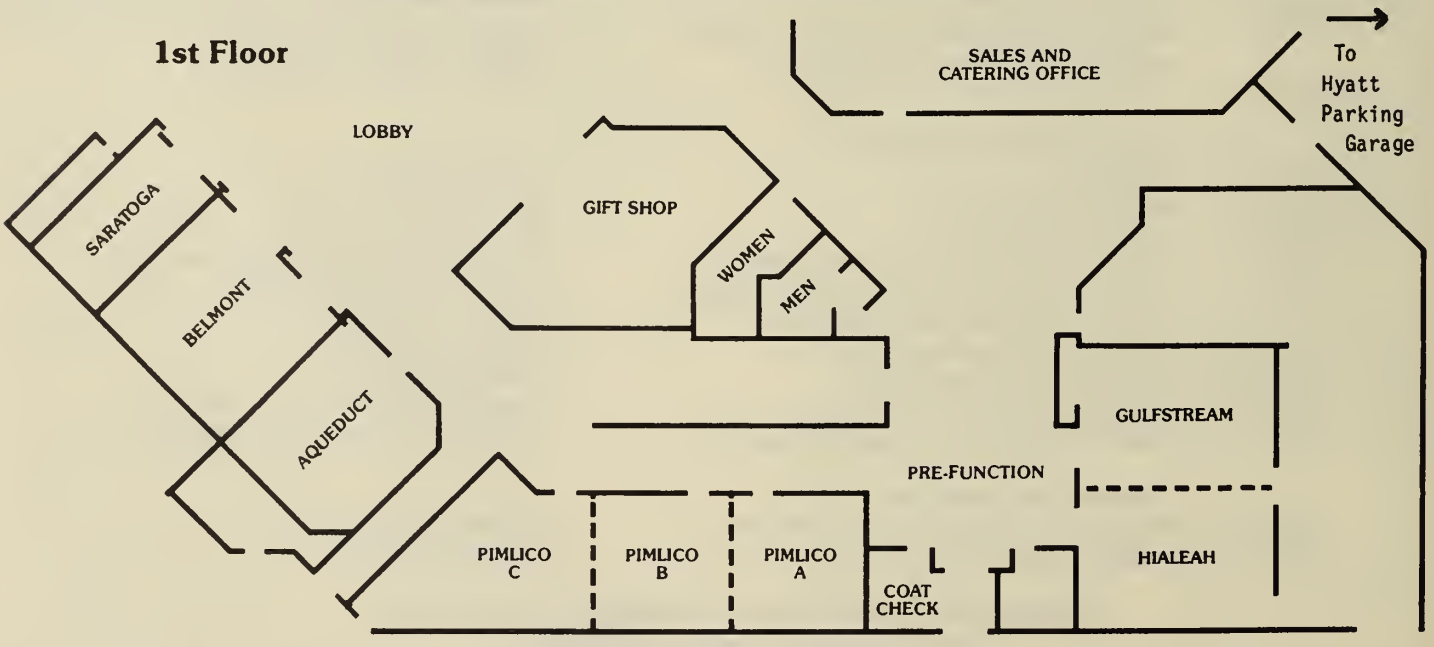
A 30-minute intermission has been scheduled during each Scientific Session and Specialty Group Session for visiting Exhibits.

HOTEL FUNCTION SPACE

2nd Floor



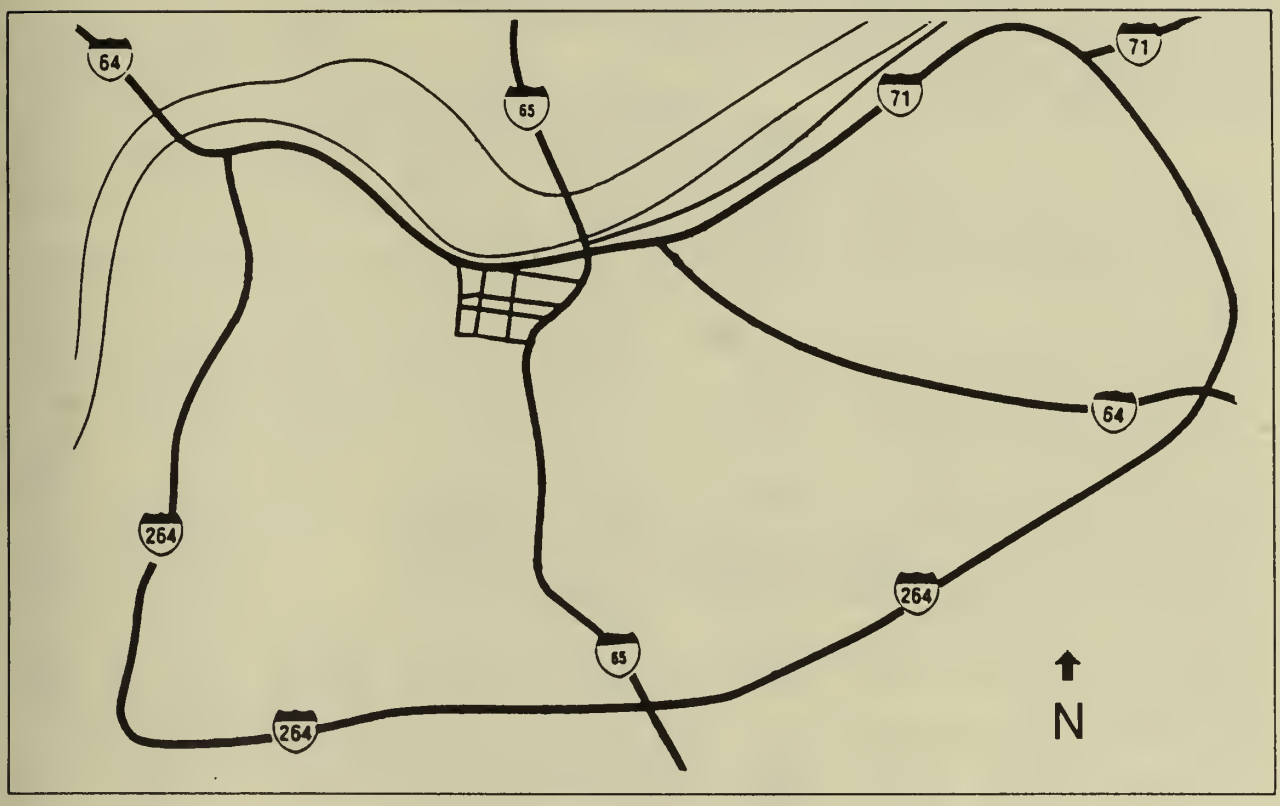
1st Floor



TEAR OUT MAPS

of Major Routes and Convenient Parking Locations in Downtown Louisville

TO REACH HYATT REGENCY/ COMMONWEALTH CONVENTION CENTER

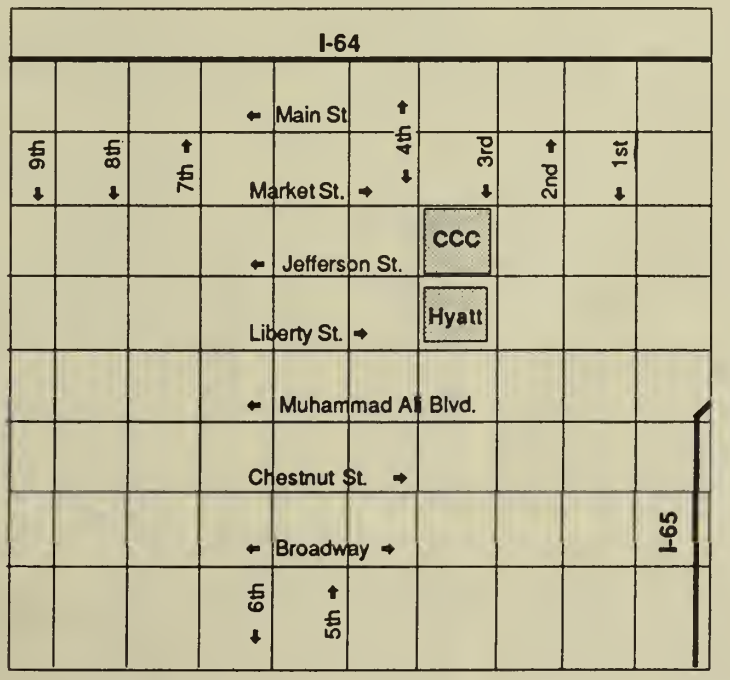


From I-64/1-71 Westbound:
Take 3rd St. exit, go south on 3rd, turn right on Jefferson.

From I-64 Eastbound:
Take 9th St. exit, go south on 9th, turn left on Market.

From I-65 Northbound:
Take Muhammad Ali Blvd. exit, go west on Muhammad Ali, turn right at 2nd St., turn left at Jefferson.

MAP INSET OF DOWNTOWN LOUISVILLE



DETAILED PARKING MAP ☛


Main Street Circulator
Trolley Route
Evening Trolley Route
Trolley Stops
Public Parking
Ohio River
Louisville Falls Fountain
I-64 (to I-71)
River Road
River Road
I-64
Riverfront Plaza/ Belvedere
Galt House
Kentucky Center for the Arts
Louisville Science Center
Fort Nelson Park
Main
Actors Theatre
Bunbury Theatre
Market
Eighth
Seventh
Sixth
Fifth
Fourth
Third
Second
First
City Hall
Jefferson County Courthouse
Commonwealth Convention Center
Convention Center Expansion Area opening 1997
Jefferson
Jefferson Square
Hyatt Regency Louisville
Liberty
71
64
65
Louisville Galleria
Muhammad Ali Museum
Armory Place
Louisville Gardens
Founders Square
Muhammad Ali
Seelbach Hotel
Guthrie Green
Cheatnut
85
Martin Luther King Jr. Park
The Brennan House
The Palace Theatre
Theater Square
The Brown Hotel
Macauley Theatre
Broadway
Louisville Free Public Library
Louisville Automobile Museum
York

KMA Delegates

FIRST DISTRICT

Ballard
Charlene Robinson, MD, Barlow
Calloway
Carlisle
Fulton
Graves
Charles Bea, MD, Mayfield
Gerald Russell, MD, Mayfield
Hickman
Livingston
Stephen Burkhart, MD, Salem
Marshall
McCracken

SECOND DISTRICT

Daviess
William Harrison, MD, Owensboro
David Jones, MD, Owensboro
Wathen Medley, MD, Owensboro
William Milnor, MD, Owensboro
Linda Mumford, MD, Owensboro
Terry Tyler, MD, Owensboro
William Tyler, MD, Owensboro
Hancock
Henderson
Scott Watkins, MD, Henderson
John Cave, MD, Henderson
Marshall Howell, MD, Henderson
McLean
Ohio
Union
Webster

THIRD DISTRICT

Caldwell
Christian
Crittenden
Hopkins
Wallace Alexander, MD
James Bowles, MD, Madisonville
Uday Dave, MD, Madisonville
Allen Elliott, MD, Madisonville
Mohan Rao, MD, Madisonville
Lyon
Madisonville
Muhlenberg
Todd
Trigg

FOURTH DISTRICT

Breckinridge
Bullitt
Grayson
Gay Fulkerson, MD, Leitchfield
Green
Hardin
Jeff Richardson, MD, Elizabethtown
Lucian Moreman, MD, Elizabethtown
David Zoeller, MD, Elizabethtown
Hart
Larue
Marion
Richard V. Steeves, MD, Lebanon
Meade
Ray Mathis, DO, Brandenburg
Nelson
Taylor
David Montgomery, MD, Campbellsville
Washington

FIFTH DISTRICT

Jefferson
Jannice Aaron, MD, Louisville
David T. Allen, MD, Louisville
Kenneth C. Anderson, MD, Louisville
Joe F. Arterberry, MD, Louisville
William T. Baker, MD, Louisville
Arnold M. Belker, MD, Louisville
Salvatore Bertolone, MD, Louisville
Charles J. Bisig, Jr, MD, Louisville
David H. Bizot, MD, Louisville
Harold W. Blevins, MD, Louisville
Steven M. Bloom, MD, Louisville
Rebecca J. Booth, MD, Louisville
Susan G. Bornstein, MD, Louisville
Judson R. Brewer, MD, Louisville
Mark Bronner, MD, Louisville
David E. Bybee, MD, Louisville
Peter Campbell, MD, Louisville
E. Dean Canan, MD, Louisville
Keith B. Carter, MD, Louisville
Gregory J. Ciliberti, MD, Louisville
Mark L. Corbett, MD, Louisville
Theresa M. Corrigan, MD, Louisville
Warren M. Cox, MD, Louisville
Leah J. Dickstein, MD, Louisville
R. John Ellis, MD, Louisville
Samuel G. Eubanks, MD, Louisville
Beverly M. Gaines, MD, Louisville
Wayne S. Gibson, MD, Louisville
Eugene Giles, MD, Louisville
Linda H. Gleis, MD, Louisville
Leonard A. Goddy, MD, Louisville
Harold D. Haller, Sr, MD, Louisville
Walter I. Hume, MD, Louisville
Barbara S. Isaacs, MD, Louisville
Sheri Kalbfleisch, MD, Louisville
Virginia T. Keeney, MD, Louisville
Donald R. Kmetz, MD, Louisville
Glenn E. Lambert Jr, MD, Louisville
Rudolph F. Licandro, MD, Louisville
Gerlinda L. Lowrey, MD, Louisville
Michael T. Macfarlane, MD, Louisville
Charles F. Mahl, MD, Louisville
W. Paul McKinney, MD, Louisville
Frank B. Miller, MD, Louisville
Alice E. Minter-Sauer, MD, Louisville
Hugh R. Peterson, MD, Louisville
Mark E. Petrik, MD, Louisville
Mark P. Pfeifer, MD, Louisville
Patricia M. Purcell, MD, Louisville
Steven J. Raible, MD, Louisville
Julio A. Ramirez, MD, Louisville
James E. Redmon, Jr, MD, Louisville
K. Thomas Reichard, MD, Louisville
Peter Ross, MD, Louisville
S. Randolph Scheen, III, MD, Louisville
Edward L. Scofield, MD, Louisville
G. Randolph Schrodt Jr, MD, Louisville
G. Randolph Schrodt, Sr, MD, Louisville
Jerry W. Seligman, MD, Louisville
Judah L. Skolnick, MD, Louisville
Bernard L. Speevack, MD, Louisville
Elaine Stauble, MD, Louisville
Gerald D. Temes, MD, Louisville
Rebecca A. Terry, MD, Louisville
Robert S. Tillett, Jr, MD, Louisville
Regulo J. Tobias, MD, Louisville
Stuart Urbach, MD, Louisville
Daniel W. Varga, MD, Louisville
Molloy G. Veal, MD, Louisville
Henry J. Walter, MD, Louisville
Norton G. Waterman, MD, Louisville
David R. Watkins, MD, Louisville
Sam D. Weakley, MD, Louisville
G. Derek Weiss, MD, Louisville
Fred A. Williams, MD, Louisville
Russell A. Williams, MD, Louisville
Janice W. Yusk, MD, Louisville

SIXTH DISTRICT

Adair
Allen
Barren
Mike Smith, MD, Glasgow
Warren Eisenstein, MD, Glasgow
Butler
Cumberland
Joseph D. Skipworth, MD, Burkesville
Edmonson
Omkar N. Bhatt, MD, Brownsville
Logan
Metcalfe
Monroe
Simpson
Warren

SEVENTH DISTRICT

Anderson
Carroll
Samer Hussein, MD, Carrollton
Franklin
Arba Kenner, MD, Frankfort
John Patterson, MD, Frankfort
Joseph Dobner, MD, Frankfort
Gallatin
Grant
Henry
David Jones, MD, Eminence
Oldham
Brooks Jackson, MD, Shelbyville
Owen
Shelby
Ron Waldridge, MD, Shelbyville
Spencer
Kenneth Oder, MD, Taylorsville
Trimble
Frank Palmer, MD, Bedford



EIGHTH DISTRICT

Boone
Michael Robinson, MD, Edgewood
Neal Moser, MD, Crestview Hills
Allan Hallquist, MD, Edgewood
Campbell
Steve Steinkamp, MD, Edgewood
Kenton
Joe Martin, MD, Cold Spring
Michael Kirkwood, MD, Edgewood
Ted Miller, MD, Edgewood
Bob Schwartz, MD, Edgewood
Gordon Air, MD, Crestview Hills
Jim Farrell, MD, Crestview Hills
Dan Fagel, MD, Crestview Hills
Chris Bolling, MD, Crestview Hills
Ross McHenry, MD, Edgewood
Kevin Martin, MD, Edgewood
Richard Park, MD, Edgewood

NINETH DISTRICT

Bath
Bourbon
Bracken
Fleming
Glenn R. Womack, MD, Flemingsburg
Harrison
Todd Ussery, MD, Cynthiana
Mason
David Doty, MD, Maysville
Nicholas
Wendell R. Kingsolver, MD, Carlisle
Pendleton
Robertson
Scott

TENTH DISTRICT

Fayette
James R. Bean, MD, Lexington
David J. Bensema, MD, Lexington
Kathleen Bos, MD, Lexington
Terry Clark, MD, Lexington
John W.Collins, MD, Lexington
Waller L. Dalton, MD, Lexington
Ernest L. Fletcher, MD, Lexington
Richard D. Floyd, MD, Lexington
John M. Fox, MD, Lexington
Terrence R. Grimm, MD, Lexington
Bill H. Harris, MD, Lexington
Tamara James, MD, Lexington
Magdalene Karon, MD, Lexington
Dennis B. Kelly, MD, Lexington
Daniel E. Kenady, MD, Lexington
John M. Moore, MD, Lexington
Gregory V. Osetinsky, MD, Lexington
Charles L. Papp, MD, Lexington
Barbara Phillips, MD, Lexington
John W. Poundstone, MD, Lexington
Michael Rukavina, MD, Lexington
Nat H. Sandler, MD, Lexington
Glenn R. Shearer, MD, Lexington
Susan E. Spires, MD, Lexington
David B. Stevens, MD, Lexington
John D. Stewart, II, MD, Lexington
Dale E. Toney, MD, Lexington
Henry G. Wells, Jr, MD, Lexington
John R. White, MD, Lexington
Emery A. Wilson, MD, Lexington
William O. Witt, MD, Lexington
Jessamine
Woodford

ELEVENTH DISTRICT

Clark
Estill
Jackson
Lee
James Noble, MD, Beattyville
Madison
Menifee
Montgomery
Owsley
Powell
Wolfe

TWELFTH DISTRICT

Boyle
Brian Ellis, MD, Danville
Arthur K. Rivard, MD, Danville
Scott Scutchfield, MD, Danville
Casey
Clinton
Michael Cummings, MD, Albany
Garrard
Paul J. Sides, MD, Lancaster
Lincoln
McCreary
Mercer
George Noe, MD, Harrodsburg
Pulaski
Steve DeMunbrun, MD, Somerset
Debra Eadens, MD, Somerset
Billy Joe Parson, MD, Somerset
James Wilson, MD, Somerset
Rockcastle
William McElwain, MD, Mt. Vernon
Russell
H. Michael Oghia, MD, Russell Springs
Wayne

THIRTEENTH DISTRICT

Boyd
George Aitken, MD, Ashland
Maurice Oakley, MD, Ashland
Roger Potter, MD, Ashland
Susan Prasher, MD, Ashland
Charles Watson, MD, Ashland
Carter
Elliott
Greenup
John Jones, MD, Flatwoods
Manuel Garcia, MD, Ashland
Lawrence
Lewis
Morgan
Rowan
Tom Newcomb, MD, Morehead

FOURTEENTH DISTRICT

Breathitt
Floyd
Roger Jurich, MD, Prestonsburg
Debra Hall, MD, Prestonsburg
Johnson
Knott
Letcher
Magoffin
Martin
Perry
Gil Daley, MD, Hazard
Syamala Reddy, MD, Hazard
Pike
Charles Nichols, MD, Pikeville
Greg Hazelett, MD, Pikeville
Rakesh Sachdeva, MD, Pikeville

FIFTEENTH DISTRICT

Bell
Francisco Mappala, MD, Middlesboro
Emanuel Rader, MD, Pineville
Clay
Ira F. Wheeler, MD, Manchester
Harlan
Gordon Hollins, MD, Harlan
Knox
W. Scott Black, MD, Barbourbville
Laurel
Leslie
Whitley
Bruce Barton, MD, Corbin
Rod Weisert, MD, Corbin
Kathy Martin, MD, Corbin

KMA Student Section
UL – Kate Wilson, Louisville
UK – LaDonya Reed, Lexington

KMA Resident Physicians Section
Kirsten Cooper, MD, Madisonville

KMA Organized Medical Staff Section
John D. O'Brien, MD, Louisville

Reference Committee Activity

Speakers John W. McClellan, Jr, MD, Henderson, and Thomas K. Slabaugh, MD, Lexington, will assign all officers' and committees' reports and resolutions to one of five reference committees at the first meeting of the KMA House of Delegates at 10:00 AM, Monday, September 21. A brief session for reference committee chairs will be held at 12:00 noon, Monday, in the Derby Room, located on the second floor of the Hyatt Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the reference committee meetings which will be held at 1:00 PM, Monday, September 21, in the first floor meeting rooms in the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports, review the testimony, and write their reports to the House.

The committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 23, in the Regency Ballroom, Hyatt Hotel.

Appointments for reference committees, the Credentials Committee, and Tellers are now being finalized by the Speakers. If your society has not yet submitted the name of your delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the reference committees and be listed as official county society representatives.

AN INVITATION TO ALL SENIOR AND/OR RETIRED MEMBERS OF KMA TO THE STATEWIDE CATO SOCIETY MEETING OF THE SENIOR PHYSICIANS OF JEFFERSON COUNTY
9:30 AM
WEDNESDAY, SEPTEMBER 23, 1998
THE HYATT REGENCY HOTEL, LOUISVILLE, KY

Here is an opportunity for senior and/or retired members of KMA to meet old colleagues and make new friends at the 9th Annual Statewide CATO Society Meeting, held during the KMA Annual Meeting. This year the CATO Society meeting will be held at the Hyatt Regency Hotel in Louisville, Kentucky. It will begin with a breakfast buffet at 9:30 AM in the Keeneland Suite.

The CATO Society is an integral part of the Jefferson County Medical Society and its Senior Physicians Committee. We have meetings in the Spring and Fall that are primarily for fellowship. We gather for a light meal followed by an enlightening but brief address on some informative or entertaining topic.

Last year's meeting was an immense success with a large crowd of senior physicians from the Kentuckiana area.

Again this year, we cordially invite spouses and widows to attend.

Watch the mail for your invitation, complete the form, and share a time during breakfast with your colleagues. We look forward to visiting with you.

Eugene H. Conner, MD
President, Jefferson County CATO Society

1998 Risk Management Seminars

Presented by Kentucky Medical Insurance Company (KMIC)
A Subsidiary of Michigan Physicians Mutual Liability Company (MPMLC)

For Medical Office/Clinic Staff: Dis'ing Your Patients

(How to Take the 'Dis' Out of 'Discontent')

Monday, September 21, 1998
9:00 am – 11:00 am
Hyatt Regency Louisville
Registration Deadline: Monday, September 14, 1998

This seminar is recommended for all medical office and clinic staff personnel. This seminar was developed to give office personnel the tools and techniques needed to reduce stress when dealing with a discontented patient. We will discuss how to improve communications skills between medical office personnel and patients, how emotions can affect compliance and communications, and how to reduce the risk of being involved in a lawsuit. This program will involve scenarios in which the participants will play a role in taking the 'dis' out of a discontented patient.

Seminar Objectives: Participants can expect to learn how to improve their own communication skills when dealing with others; to identify and control their own emotions and to understand patients' emotions; know how to diffuse a problem situation; and reduce their risk of being involved in a lawsuit.

Cost: $25.00 per staff member for Kentucky Medical's insured physician offices. $50.00 per staff member for non-insured offices.

Premium Credit: KMIC-Insured physicians will receive a 3% premium credit on their next policy renewal if half of their office staff attends the program. (The maximum annual credit is 5% per physician.)

CEUs: The MPMLC/KMIC office staff seminars have been approved by the American Association of Medical Assistants (AAMA) for 2.0 general Continuing Education Units (CEUs). CEUs are granted at no charge to members of the AAMA who complete these seminars. For non-members, a $5 transcript fee is due prior to the seminar.

For Physicians: Painful Liability Issues

Tuesday, September 22, 1998
12:00 pm – 2:30 pm
Hyatt Regency Louisville
Registration Deadline: Monday, September 14, 1998

This seminar is for physicians of any specialty who are currently practicing pain management techniques, or plan on offering this type of treatment in the future. Physician assistants and nurse practitioners are welcome to attend. This is an entertaining and informative seminar to update and inform physicians regarding the treatment of painful maladies. Avoiding liability issues will be a major focus. A luncheon buffet will be provided from 12:00 – 12:30.

Seminar Objectives: The learner will gain an understanding of appropriate diagnostics, the necessity of treatment protocols, patient selection criteria, and how to avoid liability issues relative to the treatment of painful maladies.

Cost: $50.00 per physician, includes the luncheon buffet.

Premium Credit: Physicians insured with Kentucky Medical Insurance Company will receive the maximum 5% premium credit on their next policy renewal. *Participants must attend the entire seminar program and complete required forms to be eligible for premium credit and CME credit.*

CME Statement: Michigan Physicians Mutual Liability Company (MPMLC) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

MPMLC/KMIC designates this activity for a maximum of 2 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

To request a registration form for the above seminars, call Risk Management Services at Kentucky Medical Insurance Company either toll-free at 1-800-467-1858 or in Louisville at 339-5700. For more information about other seminar dates, visit our website at www.mpmlc.com.



1998 KMA Annual Meeting Honors Past President

Milton Board, MD



The 1998 Annual Meeting of the Kentucky Medical Association will be officially titled "The Milton Board Meeting" in remembrance of the 1916 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Board that begins on the next page.

SCIENTIFIC SESSIONS are scheduled for Tuesday and Wednesday, at the Commonwealth Convention Center in Louisville. The theme for the 1998 scientific session is "The Team Approach to Healthcare: The Physician's Role." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

TWENTY-ONE SPECIALTY GROUPS will hold meetings on September 22 and 23 beginning at 1:30 PM on Tuesday and 2:15 PM on Wednesday. Individual programs of specialty societies and meeting locations are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet both days with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

SCIENTIFIC AND TECHNICAL EXHIBITS will display new medical products, services, and techniques in the Exhibit Hall, located in the Commonwealth Convention Center during the 1998 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

THE KMA HOUSE OF DELEGATES will meet twice during the Annual Meeting. The first meeting of the House will be held at 10:00 AM, Monday, September 21 in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, September 23, at 7:00 PM, in the Regency Ballroom. Officers for the 1998-99 Associational year will be elected at the second meeting.

THE PRESIDENT'S INSTALLATION & AWARDS LUNCHEON will be held on Wednesday, September 23, in the Regency Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1998-99 President, Donald R. Stephens, MD, Cynthiana.



Milton Board, MD [1870-1950]



This Annual Meeting of the Kentucky Medical Association (KMA) being held in Louisville, Kentucky, on September 21-25, 1998, memorializes Milton Board, MD. During his long, varied and distinguished career, he applied his skills as practitioner, administrator and public speaker in the service of his patients, the medical profession, the state government of Kentucky and the uniformed services. He had been elected President of the KMA at its Annual Meeting in Hopkinsville on October 25, 1916.[1]

Dr. Board was born in Hardinsburg, Breckenridge County, Kentucky, October 4, 1870, the son of Judge Milton and Sue Lewis (nee Moorman) Board, to whom five children were born. He was educated in the public schools of Breckenridge County and attended Breckenridge Normal School. A.M. Kincheloe, MD, a practitioner in his hometown, served as Board's preceptor before and during his attendance at the University of Louisville Medical Department from which he received his MD in 1893. He was salutatorian of his graduating class. Following graduation he returned to Hardinsburg and began a general practice which soon kept him very busy for over a decade. In 1904, he left Hardinsburg to pursue specialty practice in nervous and mental diseases, having been appointed Superintendent of The Western Kentucky Asylum for the Insane in Hopkinsville, Christian County. Here he remained until 1906, when he resigned to accept an appointment by governor John C. W. Beckham to the State Board of Control of Charitable Institutions.[2,3] The following year, Governor August E. Wilson appointed him to the State Board of Corrections. During these years of state duties, however, Dr. Board continued to devote his professional skills to the care of private patients disabled by nervous and mental disease.

In 1908, he opened one of the early private sanitoria in Louisville for the treatment of mental and nervous diseases, drug and liquor habits at 1412 Sixth Ave. His family residence was next door and connected to the sanitorium by a hallway.[4] A few years later, he was appointed Lecturer in Psychiatry at the University of Louisville Medical Department.[5] By 1914, the sanitorium had become formalized with officers and a Board of Directors. Dr. Board remained President and Superintendent, assisted by Drs. J. T. Windell, Earl Moorman, W. E. Gardner and A. T. McCormack. In September, 1916, he discontinued his association with the sanitorium but the facility and its staff, under the direction of William E. Gardner, MD, continued to serve patients as the Louisville Neuropathic Sanitorium.[6] Dr. Board continued to practice his specialty from offices in the Weissinger-Gaulbert Building.

Milton Board, never one to shun difficult problems, was often asked to serve on committees charged with addressing topics which were controversial. At the KMA meeting of September, 1915, President John J. Moren, MD, appointed Dr. Board Chairman of the Reference Committee on Division of Fees, to be assisted by G. P. Grigsby, MD, Louisville, and R. C. McChord, MD, Lebanon. The Committee's Report was straightforward: "We condemn without reservation fee-splitting between specialist and general practitioner . . . As the law gives the State Board of Health the power to revoke the license of any physician guilty of unwarrantable conduct, we recommend that the fee-splitter be made an example of the efficacy of this report." Their report was adopted.[7] Dr. Board also served as a "referee" for Jefferson County on the question of fee-splitting.[8] This matter of fee-splitting continued to occupy the attention of county societies and the KMA until mobilization of troops for service during WWI refocused attention to supplying physicians to the military.

While President of the KMA, on 30 August 1917, Dr. Board was commissioned Major in the Medical Reserve Corps (MRC) of the US Army and ordered to active duty as Chief of the Department of Mental and Nervous Diseases at the Hospital at Camp Zachary Taylor, Louisville, Ky. He

remained at Camp Taylor for his entire tour of active duty which ended when he was mustered out in September 1919. He remained in the MRC until 1925, and was discharged a Lt. Colonel.

He joined the United States Public Health Service soon after leaving active duty in the Army and was assigned to service with the Kentucky State Board of Health. In January 1921, however, he was sent as Senior Surgeon to the Hospital Division of the USPHS in Washington, D.C. As a neuropsychiatrist, he was a consultant for WWI veterans who were receiving care at various government hospitals in the Washington, D.C. area.[9]

Dr. Board was a life-long member of the Methodist-Episcopal Church South and as a firm believer in its tenets, he himself never used tobacco, alcohol or narcotics. Having gained considerable experience and developing a great interest in the treatment of patients who had become substance abusers, Dr. Board shared his knowledge with professional colleagues. After having spent over a decade caring for such patients, he offered his discussion of a paper presented to the KMA Annual Meeting by John A. Snowden, MD, of Winchester, Kentucky, on the Home Treatment and cure of opium and morphine addicts.[10] Dr. Board disagreed with Dr. Snowden and emphasized his own and the conclusions of others that "naturally acquired" morphinism (addiction not acquired in the course of medical treatment) is 100% incurable.[11]

Much ahead of his time, Dr. Board urged the medical profession to shun the use of tobacco, and in discussion, claimed "the use of tobacco is a baneful habit, if habit it is. The cigarette smoking predisposes to nervousness, and the nervousness in turn predisposes to the more excessive use of cigarettes."[12] In his discussion of a paper on the management of the eclamptic patient, Dr. Board observed that mercurial diuretics, used in treatment, by their inherent toxicity could cause or exacerbate the central nervous system disturbances associated with eclampsia.[13]

Dr. Board maintained an office for his private specialty practice and was an active participant in the affairs of the Jefferson County Medical Society (JCMS) and the KMA. He kept an active membership in JCMS from 23 November 1908, when he transferred his membership from the Christian County Medical Society, until he became an affiliate member after retirement, on 4 May 1936.[14]

He was a vigorous proponent of publishing the transactions of the JCMS in the monthly issues of the *KMA Journal*. He considered medical society meetings important opportunities for continuing medical education which warranted the *Journal*'s wide dissemination to the larger medical community.[15,16]

Board spoke often at medical society meetings and when president, addressed county and regional societies throughout the state; however, he did not give a Presidential address, and he never seems to have submitted his addresses for publication.

Politics became a consuming interest and Board was recognized as wielding considerable influence in the Democrat Party of Kentucky. He served many years (1910-1934), in important offices under five Kentucky governors, but never held an elective office. On several occasions he incurred the enmity of the party for acting upon the dictates of his own conscience.

Dr. Board and Isabel Miller, of Hardinsburg, were married on 15 May 1895. To them were born four children: Agnes, Robert C., Milton (died at age 2) and Isabel. Their two daughters, Mrs. Agnes B. Dodd and Mrs. Clyde Foshee (Isabel), survived both parents. Dr. Board and his wife, until her death, spent winters in Orlando, Florida, a practice he continued alone until his death on Wednesday, 29 March 1950.[17]

Dr. Milton Board, whom we honor at this memorial meeting, served his patients, colleagues and fellow citizens with honesty, wisdom and sincerity in medicine, politics and government.

Eugene H. Conner, MD
KMA Historian

I wish to thank Dr. Milton Board's daughter, Isabel Foshee and her husband, Clyde H. Foshee, MD, for their assistance in preparing this memorial.

References

1. *Kentucky Medical Journal. (KMJ) 14*, 613-614 (Dec. 1) 1916.
2. Kerr, Judge Charles, Editor, *History of Kentucky in Five Volumes*, The American Historical Society, Chicago and New York, 1922. *3*, 112-113.
3. Dr. Board's Sanatorium. *KMJ, 12* adv. p.xxi (Nov 1) 1914.
4. *Polk's Medical Register and Directory of North America*. Eleventh revised edn., R. L. Polk & Co., Detroit, Baltimore and Chicago, 1910. p. 757.
5. *University of Louisville Bulletin 9*, 90 (May) 1915.
6. Louisville Neuropathic Sanatorium. *KMJ 14*, adv. p. xx, (Dec 1) 1916.
7. Official Minutes of the House of Delegates . . . *KMJ, 13*, 559 (Nov 1) 1915.
8. Official Minutes of the House of Delegates . . . *KMJ, 12, 665 (Nov 1) 1914.*
9. "Dr Milton Board, 79, dies suddenly in Lexington on way from Florida." *Courier-Journal*, Louisville, Thursday, March 30, 1950. *191*, Sect 2, p. 1, cols [1-3].
10. Snowden, JA, Home treatment and cure of opium and morphine addicts . . . *KMJ 15* 125-131 (March 1) 1917.
11. Ibid. Dr Board's discussion is on p. 130.
12. Ibid. *12*, 297 (May 15) 1914.
13. Ibid. *12*, 384, (June 15) 1914.
14. Membership files of JCMS.
15. Ibid. *12*, 664-5 (Nov 1) 1914.
16. Ibid. *15*, 89 (Feb 1) 1917.
17. Vide supra #9.



Introducing the Guest Speakers

ANESTHESIOLOGY



Joel A. Kaplan, MD
Louisville, KY
Deon, University of Louisville School of Medicine; Vice President of Health Affairs; Senior Vice Provost for Academic Affairs; Professor of Anesthesiology.

PLASTIC & RECONSTRUCTIVE SURGERY



Henry S. Byrd, MD
Dallas, TX
Professor Clinical Surgery, Department of Surgery; Vice Chair and Chief of Pediatric Plastic Surgery Section, Department of Plastic Surgery, University of Texas Southwestern Medical Center.

DERMATOLOGY



Ronald P. Rapini, MD
Lubbock, TX
Professor and Chair, Department of Dermatology, Professor of Pathology, Texas Tech University.

PHYSICAL MEDICINE & REHABILITATION



Thomas W. Findley, MD
Upper Montclair, NJ
Hunterdon Professor and Director of Neuromuscular Institute, UMDNJ-School of Osteopathic Medicine; Adjunct Associate Professor, Physical Medicine and Rehabilitation UMDNJ-New Jersey Medical School.

OBSTETRICS/GYNECOLOGY



Jeffrey C. King, MD
Beavercreek, OH
Professor and Vice Chair, Department of OB/GYN, and Director, Division of Maternal-Fetal Medicine, Wright State University School of Medicine.

NEUROLOGY



James J. Corbett, MD
Jackson, MS
Chair and McCarty Professor of Neurology/Professor of Ophthalmology, University of Mississippi Medical College.

ORTHOPAEDICS



Edward N. Hanley, Jr, MD
Charlotte, NC
Chair, Dept of Orthopaedic Surgery, Carolinas Medical Center; V-Pres, Clinical Activities, Medical Education and Research, Carolinas HealthCore System; Clinical Prof of Surgery and Adjunct Prof of Biomedical Engineering, Univ of North Carolina.

EYE PHYSICIANS & SURGEONS



Paul S. Koch, MD
Warwick, RI
Private practice, Koch Eye Associates. *Ophthalmology Times*: Top 100 Ophthalmologists in America/One of Top 15 Cataract Surgeons in America.

GASTROENTEROLOGY



Byron L. Cryer, MD
Dallas, TX
University of Texas Southwestern Medical Center, Assistant Professor of Medicine; Dallas VA Medical Center.

EMERGENCY PHYSICIANS



James J. Augustine, MD
Dayton, OH
Assistant Director, Emergency & Trauma Center; Medical Director, EMS, Miami Valley Hospital; Associate Clinical Professor, Wright State University.

PSYCHIATRY



Thomas P. Beresford, MD
Denver, CO
Professor, Department of Psychiatry, University of Colorado. Assistant Editor, *Psychosomatics*.

FAMILY PHYSICIANS



Reid B. Blackwelder, MD
Kingsport, TN
Program Director, Kingsport Family Practice Residency. Associate Professor, Family Medicine, East Tennessee State University.

COLLEGE OF SURGEONS



Mark A. Malangoni, MD
Cleveland, OH
Choirperson, Dept of Surgery, MetroHeolth Medicol Center; Praf ond V-Chair, Dept of Surgery, Case Western Reserve Univ Schaol of Medicine; Director, American Board af Surgery, Americon Boord of Emergency Medicine.

PEDIATRICS



Calvin C.J. Sia, MD
Honolulu, HI
Clinical Prafessor of Pediotrics, University of Howoii School of Medicine. Post President, Hawoii Stote Medicol Associotion.

COLLEGE OF PHYSICIANS



Harold C. Sox, MD
Lebanon, NH
Professor of Medicine & Choir, Department of Medicine, Dortmouth Medicol School. President, Americon College of Physicions.

ALLERGY & CLINICAL IMMUNOLOGY



Emil J. Bardana, MD
Portland, OR
Professor of Medicine, Heod, Division of Allergy ond Clinical Immunolagy, Oregon Heolth Services University.

NEUROSURGEONS



Martin Blacker, MD
Houston, TX
Directar of Resident Educotion, Department of Neurasurgery, Baylar College af Medicine, Houstan.

PATHOLOGISTS



Stephen Raab, MD
Pittsburgh, PA
Associote Professor with Tenure, Dept of Pothology, University of Iowo Hospitals & Clinics; Associote Professor with Tenure, Dept of Pathalogy & Loborotory Medicine, Allegheny University of Heolth Sciences, Medicol College of Pennsylvania & Hohnemonn University.

GERIATRICS

(Photo nat available)

Christine S. Ritchie, MD
Watertown, MA
Adjunct Assistont Professor, Boston University Medicol Center; Assistont Professor, University of Alobomo ot Birminghom.

OCCUPATIONAL MEDICINE

(Photo not available)

David A. Petruska, MD
Louisville, KY
Neurosurgicol Group of Greoter Louisville ond Sauthern Indiana, PSC.

PUBLIC HEALTH PHYSICIANS

(Photo nat available)

Glyn G. Caldwell, MD
Frankfort, KY
Director, Division of Epidemiology & Heolth Plonning Deportment for Public Heolth, Fronkfort



General Sessions Learning Objectives

KENTUCKY ORTHOPAEDIC SOCIETY
Spinal Stenosis: Classification and Treatment
Edward N. Hanley, Jr, MD
The learning objectives are to be able to describe the various forms of lumbar spinal stenosis, the presenting symptoms and findings associated with spinal stenosis, the appropriate nonoperative treatment measures for lumbar spinal stenosis, and the indications for appropriate techniques of an outcomes for surgical treatment for lumbar spinal stenosis.

KENTUCKY PSYCHIATRIC ASSOCIATION
How Can We Trust These People? Team Decision in Accepting Alcoholics for Liver Transplant
Thomas Beresford, MD
The objective is to demonstrate the need for teamwork in accepting high risk patients for special medical or surgical procedures. Based on the speaker's experience with liver transplant candidates, at the conclusion of the talk the audience should understand the use of team interaction and the role of team members in the decision process.

KENTUCKY ACADEMY OF EYE PHYSICIANS AND SURGEONS
Team Approach to Surgery
Paul Koch, MD
The learning objective is to learn how to lead the establishment of effective and efficient care in cataract surgery a) in ambulatory surgery centers, and b) in hospital outpatient departments.

KENTUCKY CHAPTER, AMERICAN COLLEGE OF PHYSICIANS
Controversies in Screening in Internal Medicine
Harold C. Sox, Jr, MD
The objectives are to understand the principles of screening and evidence-based medicine applied to screening.

KY CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Emergency Departments of the Future: Workforce of the Future
James J. Augustine, MD
The objectives are to discuss the evolution of Managed Care Organizations (MCOs) in the Midwestern region, with specific reference to the major payors; to explain managed care marketing and competitive pressures as related to physician practice; to demonstrate various reimbursement practices, and the likely evolution in the Midwest region; to discuss affiliation options for physicians, hospitals, and systems of providers; and to present methods of implementing market solutions in medical and Emergency Medicine practice.

KENTUCKY CHAPTER, AMERICAN COLLEGE OF SURGEONS
Evolution in Health Care: The Challenge of Physician Leadership
Mark Malangoni, MD, FACS
The objectives are to understand the importance of the physician in a changing health care system; to recognize the contribution that physicians can make to health care organizations; and to acknowledge that the physicians have a leadership role in the changing health care environment.

KENTUCKY PEDIATRIC SOCIETY
Medical Home and Children with Special Health Care Needs
Calvin C. J. Sia, MD
The objective is an understanding of the role of the primary care provider (the medical home) and his/her relationship to the healthcare of children with special health care needs. This will encompass an understanding of the concept of the medical home, definition of children with special health care needs, and the importance of team approach to care coordination and case management.

KENTUCKY SOCIETY OF GASTROINTESTINAL ENDOSCOPY
Update on Non-Steroidal Anti-Inflammatory Drugs—Will the Next Generation of NSAIDs be Safer?
Byron Cryer, MD
By the completion of the presentation the attendee should be able to list major side-effects of NSAIDs, list the mechanisms through which NSAIDs cause damage, list groups at high risk for NSAIDs-induced damage, and describe why selective cyco oxygenase inhibitors might be safer than currently available NSAIDs.

KENTUCKY SOCIETY OF ALLERGY, ASTHMA, AND CLINICAL IMMUNOLOGY
The Science of Things That Are Not
Emil J. Bardana, MD
The objectives are to understand how pseudoscience has been a part of the evolution of medicine up to the present time, to know what is meant by the scientific method in the assessment of causation, distinguish between medical and legal analysis of causation, and to understand the elements of differentical diagnosis in evaluating the patient with "chemical sensitivity."

KENTUCKY OB/GYN SOCIETY—KENTUCKY SECTION ACOG
Premature Labor Management
Jeffrey C. King, MD
The objectives are to discuss the incidence and impact of preterm labor, outline the clinical signs and symptoms of patient presentation, discuss current options for uterine tocolysis, and describe adjunctive therapies for management of preterm labor.

KENTUCKY SOCIETY OF ANESTHESIOLOGISTS
Evolution of Faculty Practice Plans
Joel Kaplan, MD
In this session, physicians would learn the history of faculty Practice Plans in academic medical centers, the scope of Practice Plans, and the way academic physicians are dealing with changes produced by managed care.

COMMONWEALTH NEUROLOGICAL SOCIETY

Diagnosis and Treatment of Myasthenia Gravis

James J. Corbett, MD

The objectives are to be able to recognize the symptoms and signs of myasthenia gravis: to know how to establish the diagnosis; and to know what treatment options are available.

KENTUCKY SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

Physician Strategies in "Care Management"

Henry Steven Byrd, MD

The objectives are to define the difference between managed care and care management, discuss pitfalls in managed care that effect physician's bottom line, discuss local Texas trends in managed care that differ from East Coast and West Coast, and discuss methods of leveling the "playing field" with payor mergers.

KENTUCKY CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

A Practical Approach to Alternative Medicine

Reid Blackwelder, MD

The objectives are to realize that patients utilize many therapies physicians do not prescribe, and often are not trained in; recognize the importance of allowing for open communication in the patient-physician relationship in order to discover all modalities of care; understand when certain alternative/ complementary/ integrative therapies can be beneficial; learn how physicians can and already do integrate many therapies in their treatment of patients; and review easily accessible resources for providing broad and specific information about other healing systems.

KENTUCKY SOCIETY OF PATHOLOGISTS

Patient outcomes for Pathologists: What, Why and How

Stephen S. Raab, MD

Different methods of outcomes analysis that are important to the practicing pathologist will be presented. An example that will be discussed in detail will be how outcomes analysis may be used to evaluate automated cytology technologies. By evaluating specific outcomes such as cost, patient life expectancy, turnaround time, false negative and false positive rates, the practicing pathologist may determine which, if any, automated cytology technologies should be used in his or her laboratory.

KENTUCKY NEUROSURGICAL SOCIETY

Exercises That Really Work for Back Pain

Martin Blacker, MD

The objective is that the participants gain an understanding of the use of exercises for back rehabilitation. They will learn exercises appropriate for rehabilitating their patients.

The Kentucky Medical Association will present

"CONTRACTING ISSUES FOR PHYSICIANS"

To be held on Tuesday, September 22, 1998, at the KMA Annual Meeting. To accommodate those who will be attending specialty programs, this program will be held at two separate times:

12:00 – 1:30 pm
2:00 – 3:30 pm

The program will review contractual issues between physicians and third party payers, using language from contracts currently in circulation throughout Kentucky.

The speaker will be Carol O'Brien, Esquire, of the American Medical Association's Division of Physician and Patient Advocacy.

This program is free and open to all KMA members.



1998 KMA ANNUAL MEETING

Scientific Program

Milton Board, MD, Meeting

C. Kenneth Peters, MD
KMA President, Presiding

Tuesday, September 22, 1998
General Sessions Area
Commonwealth Convention Center

8:30 AM	**Welcome and Announcements**
8:40 AM	**Spinal Stenosis: Classification and Treatment** Edward N. Hanley, Jr, MD, Charlotte, North Carolina *Kentucky Orthopaedic Society*
9:00 AM	**How Can We Trust These People? Team Decision in Accepting Alcoholics for Liver Transplant** Thomas Beresford, MD, Denver, Colorado *Kentucky Psychiatric Association*
9:20 AM	**The Surgical Team, in ASCs and Hospitals** Paul Koch, MD, Warwick, RI *Kentucky Academy of Eye Physicians and Surgeons*
9:40 AM	**Physician Strategies in "Care Management"** Henry Steven Byrd, MD, Dallas, Texas *Kentucky Society of Plastic and Reconstructive Surgeons*
10:00 AM	**Intermission to visit exhibits**
10:30 AM	**Emergency Departments of the Future: Workforce for the Future** James J. Augustine, MD, Dayton, Ohio *Kentucky Chapter, American College of Emergency Physicians*
10:50 AM	**Exercises That Really Work for Back Pain** Martin Blacker, MD, Houston, Texas *Kentucky Neurosurgical Society*
11:10 AM	**Controversies in Screening in Internal Medicine** Harold C. Sox, Jr, MD, Lebanon, New Hampshire *Kentucky Chapter, American College of Physicians*
11:30 AM	**Evolution in Health Care: The Challenge of Physician Leadership** Mark Malangoni, MD, FACS, Cleveland, Ohio *Kentucky Chapter, American College of Surgeons*
11:50 AM	**Adjourn**

KY Chapter, American College of Physicians

Convention Center
Meeting Room - 105
Tuesday, September 22

1:00 PM	**Registration**
1:10 PM	**Introductions** Joseph G. Weigel, MD, FACP
1:15 PM	**Associate Presentations**
2:00 PM	**ACP Update** **Controversies in Screening** Harold C. Sox, Jr, MD, FACP, President Joseph M. Huber, Professor and Chair
3:00 PM	**Intermission to visit exhibits**
3:20 PM	**Current Relevant Literature Review in Pulmonology** Barbara S. Phillips, MD
3:45 PM	**Current Relevant Literature Review in Cardiology** Kevin T. Scully, MD, FACC
4:10 PM	**Current Relevant Literature Review in Rheumatology** Lourdes Corman, MD, FACP, FACR
4:35 PM	**Current Relevant Literature Review in Endocrinology** David Bybee, MD, FACP
5:00 PM	**Adjourn**
6:00 PM	**Cocktails, Dinner, Awards** After Dinner Talk: "A Life in Internal Medicine in Kentucky" G. A. Weigel, MD
7:00 PM	**Town Meeting**

KY Association of Public Health Physicians

Convention Center
Meeting Room - 110
Tuesday, September 22

1:30 PM	**Tuberculosis – Old and New** Glyn G. Caldwell, MD
3:00 PM	**Adjourn**

KY Academy of Eye Physicians and Surgeons

Convention Center
Meeting Room - 111
Tuesday, September 22

1:30 PM **Simplifying Phacoemulsification**
Paul Koch, MD
2:15 PM **Patching for Amblyopis: Is There Another Way?**
Robbin B. Sinatra, MD
2:45 PM **Intermission to visit exhibits**
3:15 PM **Phaco Techniques**
Paul Koch, MD
4:00 PM **Multifocal IOL, Pros & Cons**
John Downing, MD
4:15 PM **Shaken Baby Syndrome, Diagnosis & Management**
Craig McCabe, MD
4:45 PM **Business Meeting**
5:30 PM **Adjourn**

KY Society for Plastic and Reconstructive Surgery

Convention Center
Meeting Room - 108
Tuesday, September 22

1:00 PM **Resident Presentation**
Clinical Problem Care Presentation
2:30 PM **Break and Business Meeting**
3:00 PM **Fellow Presentation**
4:30 PM **The Vertical Midface Lift**
Henry Steven Byrd, MD
Panel Discussion
Legislative Update
5:00 PM **Adjourn**

KY Psychiatric Association

Convention Center
Meeting Room - 106
Tuesday, September 22

1:00 PM **Diagnosis and Prognosis of Alcoholism: What We Can Learn From Special Populations**
Thomas Beresford, MD
2:30 PM **Legislative Update in Psychiatry**
Mara Osman, JD
4:00 PM **Adjourn**

KY Neurosurgical Society

Convention Center
Meeting Room - 109
Tuesday, September 22

1:00 PM **Treatment of Musculoskeletal Pain-Flying Blind**
Martin Blacker, MD
1:45 PM **How the Pharmacy Can Help You**
Jimmy Hatton, Pharm D
2:10 PM **Administrators: Why We Are Your Friends—How We Can Work Together**
Shirley Powers, Sr Exec Officer, Alliant Health Systems
2:35 PM **University of Kentucky Residents Presentation**
2:50 PM **Intermission to visit exhibits**
3:20 PM **Neurology--What I Have to Offer You**
Michael R. Swenson, MD
3:45 PM **Useful Advances in Neurological Pathology**
Joseph Parker, MD
4:10 PM **Residents Talk—University of Louisville**
4:30 PM **Further Government Intervention in Medicine**
James Bean, MD
Business Meeting
5:20 PM **Adjourn**

KY Academy of Physical Medicine and Rehabilitation

Convention Center
Meeting Room - 113
Tuesday, September 22

1:30 PM **Business Meeting**
2:00 PM **Patient Use of Complementary and Alternative Medicine: Guidelines for the Medical Practitioner**
Thomas Findley, MD, PhD
3:00 PM **Resident Presentations**
4:00 PM **Adjourn**



KY Orthopaedic Society

Convention Center
Meeting Room - 112
Tuesday, September 22

1:30 PM **Welcoming Comments and Business Meeting**
Donald L. Pomeroy, MD, President

1:35 PM **Surgery for Discogenic Back Pain**
Edward N. Hanley, Jr, MD

2:05 PM **Multiple Nerve Compression In U.E.**
TsuMin Tsai, MD

2:15 PM **Cortical Strut Graft Application for Thigh Pain Related to an Uncemented Femoral Component**
Pat Bauer, MD

2:25 PM **Radiographic Analysis of Femoral Tunnel Position in Post-Operative Anterior Cruciate Ligament Reconstruction**
James Cole, MD

2:35 PM **Glenoid Labral Tears: Clinical Presentation and Treatment**
W. Ben Kibler, MD

2:45 PM **Reinfusion Drains Following Total Knee Arthroplasty**
Kittie George, MD

2:55 PM **Chiani and Salter Osteotomy for Hip Instability in Cerebral Palsy**
Ranjan S. Maitra, MD

3:05 PM **Intermission to visit exhibits**

3:30 PM **Anterior Cervical Reconstruction Using Titanium Mesh In the Treatment of the Degenerative Cervical Spine**
Mohammad Majd, MD

3:40 PM **Impaction Allografting for Femoral Revision Surgery: Biomechanical and Histologic Experiment in Goats**
Cyna Khalily, MD

3:50 PM **Stage III and Stage IV Femoral Head Osteonecrosis Treated by Cement Inflation**
Robert Morgan, MD

4:00 PM **Patient Outcome Assessment vs. Clinical Scores in TKAs**
Lawrence A. Schaper, MD

4:10 PM **The Analysis of Syndesmotic Screws Placed for Ankle Fractures**
David King, MD

4:20 PM **Interference Screw Fixation of a Quadrupled Hamstring Graft is Improved with Precise Match of Tunnel to Graft Diameter**
David Bealle, MD

4:30 PM **Mechanics of External Fixation: A Mathematical Model**
Sanjiv Mehta, MD

4:40 PM **Lateral Column Lengthening in Pediatric Pes Planovalgus: EMED Analysis**
Richard W. Pectol, MD

4:50 PM **Noncontact ACL Injuries in the Female Athlete**
Mary Lloyd Ireland, MD

5:00 PM **Is Your Medical Practice Ready for the Year 2000?**
Carla Aldridge, Year 2000 Project Manager, St. Joseph Hospital

5:20 PM **Report from American Academy of Orthopaedic Surgeons**
Scott B. Scutchfield, MD

5:25 PM **Report from Kentucky Medical Association**
John Burch, MD

5:30 PM **Adjourn**

6:30 PM **Reception** – Vincenzo's Restaurant

7:15 PM **Dinner** – Vincenzo's Restaurant

KY Chapter, American College of Surgeons

Convention Center
Meeting Room - General Sessions
Tuesday, September 22

1:30 PM **Complications of Pancreatitis**
Mark Malangoni, MD

2:15 PM **Surgical Training in the 90s**
J. David Richardson, MD

2:30 PM **Minimally Invasive Surgery of the Esophagus**
Mark Wilson, MD

2:45 PM **Clinical Uses of RET Proto on Cogene Determination**
Mohan Rao, MD

3:00 PM **Multiple Casualties—The Heath High School Experience**
Charles Ross, MD

3:15 PM **Intermission to visit exhibits**

3:45 PM **Use of Flexible Endoscopy for Removal of Foreign Bodies of the Upper Gastro Intestinal Tract**
Eugene Shively, MD

4:00 PM **Prophylaxis of Thromboembolism**
David Spain, MD

4:15 PM **Legislative Update**
Bob DeWeese, MD

4:30 PM **Abdominal Aortic Stenting**
Edward V. Kinney, MD

4:45 PM **Transplantation**
Robert M. Mentzer, MD

5:00 PM **The Use of Ultrasound in Abdominal Trauma**
Paul Keamey, MD

5:15 PM **Adjourn**

KY Chapter, American College of Emergency Physicians

Convention Center
Meeting Room - 107
Tuesday, September 22

1:30 PM	**Preparing for the 21st Century as an ED Physician**
	James Augustine, MD, Dayton, Ohio
2:30 PM	**Adjourn**

Continuing Medical Education

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Kentucky Medical Association designates this educational activity for a maximum of 15 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

CME
American Academy of Family Physicians

This program has been reviewed and is acceptable for 15 prescribed hours by the AAFP. AAFP prescribed credit is accepted by the AMA as equivalent to AMA PRA Category 1 for the AMA Physician's Recognition Award. When applying for the AMA PRA, prescribed hours earned must be reported as prescribed hours, not as Category 1.

James L. Borders, MD, Chair Scientific Program Committee Presiding

Wednesday, September 23, 1998
General Sessions Area
Commonwealth Convention Center

8:30 AM	**Welcome and Introductions**
8:40 AM	**Medical Home and Children with Special Health Care Needs**
	Calvin C. J. Sia, MD, Honolulu, Hawaii
	Kentucky Pediatric Society
9:00 AM	**Evolution of Faculty Practice Plans**
	Joel Kaplan, MD, Louisville
	Kentucky Society of Anesthesiologists
9:20 AM	**Update on Non-Steroidal Anti-Inflammatory Drugs —Will the Next Generation of NSAIDs Be Safer?**
	Byron Cryer, MD, Dallas, Texas
	Kentucky Society for Gastrointestinal Endoscopy
9:40 AM	**The Science of Things That are Not**
	Emil J. Bardana, Jr, MD, Portland, Oregon
	Kentucky Society of Allergy, Asthma, and Clinical Immunology
10:00 AM	**Intermission to visit exhibits**
10:30 AM	**Premature Labor Management**
	Jeffrey C. King, MD, Dayton, Ohio
	KY OB/GYN Society - KY Section ACOG
10:50 AM	**A Practical Approach to Alternative Medicine**
	Reid Blackwelder, MD, Kingsport, TN
	Kentucky Chapter, American Academy of Family Physicians
11:10 AM	**Patient Outcomes for Pathologists: What, Why and How**
	Stephen S. Raab, MD, Pittsburgh, Pennsylvania
	Kentucky Society of Pathologists
11:30 AM	**Myasthenia Gravis – Diagnosis and Association**
	James Corbett, MD, Jackson, Mississippi
	Commonwealth Neurological Society
11:50 AM	**Adjourn**

KY Occupational Medical Assn

Convention Center
Meeting Room – 103
Wednesday, September 23

2:15 PM	**Controversies in Back Pain Management**
	David Petruska, MD
3:15 PM	**Adjourn**



President's Installation & Awards Luncheon

Wednesday, September 23, 1998 -- 11:50 am
Regency Ballroom - Hyatt Regency Hotel
C. Kenneth Peters, MD
KMA President, presiding
Invocation
Recognition
Awards Presentation
Richard F. Hench, MD, Lexington
Chair, Awards Committee
Installation of Don R. Stephens, MD
KMA President 1998-99

KY Society of Pathologists

Convention Center
Meeting Room - 109
Wednesday, September 23

2:15 PM	**Outcomes for Pathologists: What, Why and How Part I** Stephen S. Raab,MD
3:00 PM	**Intermission to visit exhibits**
3:30 PM	**Outcomes for Pathologists: What, Why and How Part II** Stephen S. Raab, MD
4:30 PM	**Adjourn**

KY Pediatric Society

Convention Center
Meeting Room - 110
Wednesday, September 23

2:15 PM	**Medical Home and the Challenge of Change** Calvin C. J. Sia, MD
3:15 PM	**Questions**
3:45 PM	**Adjourn**

KY Academy of Family Physicians

Convention Center
Meeting Room - 106
Wednesday, September 23

2:15 PM	**Incorporating Alternative Approaches into Your Practice** Reid Blackwelder, MD
3:00 PM	**Intermission to visit exhibits**
3:30 PM	**Spirituality and Healing: Incorporating Spirituality into Healthcare** Christina M. Puchalski, MD
4:30 PM	**Adjourn**

KY OB/GYN Society - KY Section ACOG

Convention Center
Meeting Room - General Sessions
Wednesday, September 23

1:30 PM	**Substance Abuse** Jeffrey C. King, MD
2:15 PM	**Cervical Length and Preterm Labor** James T. Kurtzman, MD
2:45 PM	**Intermission to visit exhibits**
3:15 PM	**Endometriosis: Related Pain and Infertility** Bradley S. Hurst, MD
3:45 PM	**Abnormal Uterine Bleeding** Steven T. Nakajima, MD
4:15 PM	**Adjourn**

KY Dermatological Association

UK Medical Center
Lexington, Kentucky
Wednesday, September 23

12:00 PM	**Registration**
12:00 PM	**Business Meeting** (with box lunch)
1:00 PM	**Patient Viewing**
2:00 PM	Break
2:30 PM	**New Disease Entities in Dermatology** Ron P. Rapini, MD
3:30 PM	**Discussion of Cases**
5:00 PM	**Adjourn**

Kentucky Society of Allergy, Asthma, and Clinical Immunology

Convention Center
Meeting Room - 107
Wednesday, September 23

2:15 PM	**Welcome and Introductions** Mark L. Corbett, MD
2:20 PM	**The Science of Environmental Illnesses** Emil J. Bardana, MD
3:05 PM	**Airway Manifestations of Laryngo-Pharyngeal Reflux** Brian L. Hawkins, MD
3:35 PM	**Inhaled Corticosteroids – Will They Make You Blind, Short, and Cushingoid?** Arthur H. Althaus, MD
3:55 PM	**What is the Role of the Intradermal Skin Test?** Gates E. Hoover, MD
4:15 PM	**What Time of Day to Give ICS?** David E. Pallares, MD
4:35 PM	**Questions**
4:45 PM	**KSAAI Business Meeting**
5:00 PM	**Adjourn**
6:00 PM	**Dinner at 610 Magnolia**

Commonwealth Neurological Society

Convention Center
Meeting Room – 102
Wednesday, September 23

1:30 PM	**Amaurosis Fugax and Not So Fugax** James Corbett, MD
2:30 PM	**Discussion**
3:00 PM	**Business Meeting**
4:00 PM	**Adjourn**

KY Society of Anesthesiologists

Convention Center
Meeting Room - 108
Wednesday, September 23

2:15 PM	**The Sedation and Analgesia in the Critical Care Unit** David W. Crippen, MD
3:00 PM	**Business Meeting**
4:00 PM	**Advances in Cardiac Anesthesia in the New World of Health Care** Joel Kaplan, MD
4:30 PM	**Adjourn**

KY Society for Gastrointestinal Endoscopy

Convention Center
Meeting Room - 105
Wednesday, September 23

2:15 PM	**GI Effects of NSAIDs: Unusual Manifestations and the Advent of Safer Drugs** Byron Cryer, MD
4:30 PM	**Adjourn**

KY Geriatrics Society

Convention Center
Meeting Room - 111
Wednesday, September 23

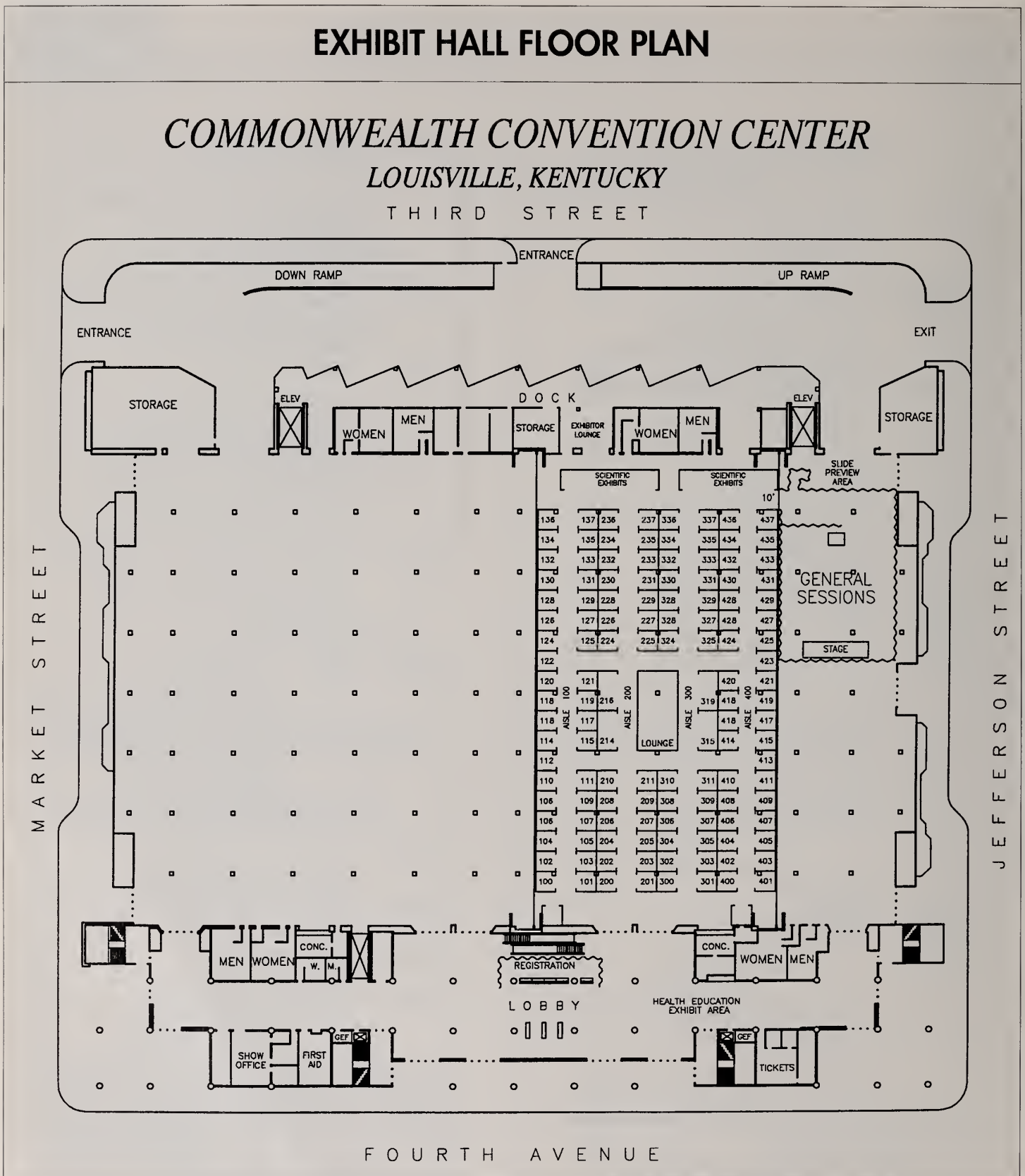
2:15 PM	**The Physician's Role in Home Health Care** Christine S. Ritchie, MD
3:15 PM	**Newer Options in Long Term Care for the Alzheimer Victim** Barbara J. Helm, MA
4:15 PM	**Business Meeting**
5:00 PM	**Adjourn**

"DOMESTIC VIOLENCE: THE ROLE OF THE PHYSICIAN IN BREAKING THE CYCLE"
Thursday, September 24, 1998
9:00 A.M. - 12:00 P.M.

9:00 AM	**Baretta Casey, MD** *Dynamics of Domestic Violence*
10:00 AM	**William Smock, MD** *Lethality and Risk Issues*
11:00 AM	**Tamra Gormley** *Legal Issues*
11:30 AM	**B. J. Jacobs** *Societal and Community Resources*

This seminar is geared to licensed primary care physicians. To maintain their license, primary care physicians must obtain a one time three (3) hour training course on Domestic Violence by June 30, 1999. This course has been approved by the Governor's Office on Domestic Violence and the Kentucky Board of Medical Licensure.

EXHIBIT HALL FLOOR PLAN



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 333, and please visit them in the Exhibit Hall.

TECHNICAL EXHIBITOR DIRECTORY

Exhibitor	Booth
AdminiStar Federal	225
AdminiStar Inc, EDI Division	224
Alliant Health System	319
AmeriPath, Inc	201
AMS Temporaries, Inc	417
Associaiton of Primary Care Physicians/ Telesis of Kentucky	202
Astra Merck	103
Audiology Solutions, Inc	411
Baptist Healthcare System	324
Bayer Pharmaceuticals	325
Cardinal Hill Healthcare System	308
CARITAS Medical Center	327
Carnrick Labs, Inc	426
CHA Health/CHA Provider Network	311
Clayton L. Scroggins Associates, Inc	423
CNA HealthPro	337
Community Physicians Network, Inc	401
Coverage Options Associates	120
Curative Wound Care Centers of Kentucky	432
Dan Binford & Associates	125
Data Management Services, LLC	430
Division of Disability Determinations	300
Doctors Insurance Reciprocal	122
Dodson Group	410
Eli Lilly and Company	336
Engravers Paper Company	434
G. D. Searle & Co	414
Glaxo Wellcome Co	310
Health Associates of Kentucky Inc	409
Health Care Partners	328
Janssen Pharmaceutica	420
Jewish Hospital Healthcare Services	415
Kentucky Medical Insurance Company	214
Kentucky Medical News	408
The Kentucky Spine Institute	306
Key Pharmaceuticals	428
The Louisville Healthcare Network	210
Mead Johnson Nutritionals	302
Medical Office System Technology, Inc	218
The Medical Protective Company	315
Merck & Co, Inc	226
Merck Vaccine Division	407
Merrill Lynch	326
MultiPlan, Inc	204
Novartis Pharmaceutical	200
Office Management Services, Inc	237
Ortho-McNeil Pharmaceutical, Inc	115
Pace Financial Corporation	419
The Pain Institute	208
Pfizer	236
Pharmacia and Upjohn, Inc	433
PHICO	424
The Physician's Inc	425
Pikeville Methodist Hospital	205
PNC Private Bank-Medical Center Team	429
Potter & Company, LLP	413
Prescription Compounding Pharmacies of Kentucky	211
Prudential Securities, Inc	111
Quest Diagnostics, Incorporated	203
Ransdell Surgical, Inc	410
Republic Bank and Trust Company	209
Rivendell Behavioral Health Services	435
Roche Pharmaceuticals	112
Roerig (Division of Pfizer)	437
Saint Joseph Hospital	400
St Mary's Health System	121
Schering Laboratories	436
SmithKline Beecham	100
SmithKline Beecham Clinical Laboratories	305
Taustine Eye Center	403
Ten Broeck Hospital	431
3M Pharmaceuticals	427
United States Army Health Care Team	101
United States Navy Reserve	104
University of Kentucky Hospital	102
VALIC	301
Voluforms	126
Wallace Laboratories	402
Whitehall-Robins Healthcare	206
Wyeth-Ayerst Laboratories	421

AN INVITATION . . .

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday and Wednesday) in the Lounge area located in the center of the Exhibit Hall, from 8:15 am - 9:00 am, for free coffee and danish.

1998 Technical Exhibits

Plan to visit the Exhibit Hall during the KMA Annual Meeting. Trained professional representatives will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing.

Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this opportunity to benefit their practice and their patients.

AdminaStar Federal **#225**
9901 Linn Station Rd
Louisville, KY 40223
(502) 425-7776
Medicare Part A Fiscal Intermediary and Medicare Part B Carrier for the Commonwealth of Kentucky.

AdminaStar Inc, EDI Division **#224**
9901 Linn Station Rd
Louisville, KY 40223
(502) 423-6756

Alliant Health System **#319**
PO Box 35070
Louisville, KY 40232
(502) 629-8653

AmeriPath, Inc **#201**
7289 Garden Rd Suite 200
Riviera Beach, FL 33404
(800) 330-6565
Diagnostic laboratories specializing in anatomic pathology. A special emphasis is placed upon catering to the specific needs of the physician.

AMS Temporaries, Inc. **#417**
519 Barret Ave
Louisville, KY 40204
(502) 581-1725

Association of Primary Care Physicians/ Telesis of Kentucky **#202**
140 Browenton Place
Louisville, KY 40222
(502) 426-9680
The Association of Primary Care Physicians (APCP) is an IPA founded by Kentuckiana primary care physicians (PCPs). In 1995, APCP partnered with Telesis, a physician management company specializing in management of PCP-directed, risk bearing IPAs. APCP/Telesis provides a vehicle for physicians to participate in managed care by:

- Offering a single source of managed care contracting
- Keeping medical decision in the hands of physicians
- Streamlining administration of managed care contracts
- Enabling physicians to assume financial risk and share in medical cost savings

Astra Merck **#103**
220 East 42nd St
New York, NY 10017
(888) 595-7737

Audiology Solutions, Inc **#411**
714 Lyndon Lane Suite #11
Louisville, KY 40222
(502) 422-6229

Baptist Healthcare System **#324**
4007 Kresge Way
Louisville, KY 40207
(502) 896-5059

Bayer Pharmaceuticals **#325**
10112 Ledbury Way
Louisville, KY 40223
(502) 244-1984

Cardinal Hill Healthcare System **#308**
2050 Versailles Rd
Lexington, KY 40504
(606) 254-5701
Cardinal Hill Healthcare System is comprised of one 100-bed post-acute rehabilitation hospital and five outpatient rehab centers, together offering comprehensive inpatient and outpatient services to both children and adults with mental and physical disabilities. Programs and services offered include treatment for brain injury, spinal cord injury, stroke, amputee, orthopedics, occupational medicine, speech, hearing, physical therapy, occupational therapy, chronic pain management, adult day health, day programs, Multiple Sclerosis and more. The system spans the central, eastern and northern parts of Kentucky and is a non-profit, CARF-accredited facility.

CARITAS Medical Center **#327**
1850 Bluegrass Ave
Louisville, KY 40215
(502) 361-6659

Carnrick Labs, Inc **#426**
65 Horse Hill Rd
Cedar Knolls, NJ 07927
(973) 267-2670

CHA Health/CHA Provider Network **#311**
191 A Lowery Lane
Lexington, KY 40503
(606) 323-0285
An Integrated Delivery Network and Accountable Health Plan serving 89 of Kentucky's 120 counties with healthcare plans. These include HMO, POS, and PPO programs designed to meet the needs of the local community from fully insured small groups to self-insured corporations.

Clayton L. Scroggins Associates, Inc **#423**
200 Northland Blvd.
Cincinnati, OH 45246
(513) 771-7070
Scroggins Associates provides financial and practice management consulting services exclusively to physicians and dentists. Impartial counsel in a professional, comprehensive and confidential manner on a fee for service basis. "Medical Economics and Physician's Management" magazines recognize our unique expertise, since we serve as editorial consultants.

CNA HealthPro **#337**
CNA Plaza 27S
Chicago, IL 60685
(312) 822-6059

Community Physicians Network, Inc **#401**
135 W Muhammad Ali Blvd
Louisville, KY 40245
(502) 589-4300

Coverage Options Associates **#120**
1302 Clear Spring Trace
Louisville, KY 40223
(502) 426-6220
Coverage Options Associates is a full service insurance services firm, providing specialized services to hospitals, physicians and other health care organizations. Our history of success reflects the pride we take in our southeastern heritage, and our belief that the best client relationships are built upon a foundation of professionalism, integrity and personal service.

We offer professional liability coverage for physicians, individual and group practice policies, through a competitive, financially sound, A.M. Best A-Rated Insurer, Doctors' Insurance Reciprocal.

Curative Wound Care Centers of Kentucky **#432**
3991 Dutchmans Lane Suite 409
Louisville, KY 40207
(502) 899-6100
The Curative Health Services network is the largest nationwide network of wound care specialists, with more than 150 wound care centers that provide comprehensive, interdisciplinary wound care with a healing rate of 80%. Wound Care Centers have successfully treated more hard to heal wounds than anyone. Founded in 1984.

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(513) 221-4800
Dan Binford and Associates is the manufacturer's representative for Towne Square glider/rockers, which feature adjustable height tables for dining rooms, activity rooms, and resident rooms; Sohu Industries, builder of quality casegoods; Schumaker Lighting, maker of lamps designed for health care applications and Nemschoff, manufacturer of fine seating and casegoods for the health care market.

Data Management Services, LLC **#430**
7606 Deer Meadow Dr
Louisville, KY 40241
(502) 893-0491
Data Management Services, LLC offers two software solutions for managing office documents and patient records.

Software from Liberty IMS converts paper documents, microfilm, and microfiche into digital form. It will index, store and retrieve records from storage devices including CD-ROMs. The Internet can link multiple office locations.

Cardiff Software's TELE*form* package extracts data (both hand and machine written) from history forms, questionnaires, and office notes. Applications such as word processors can then utilize the data.

Division of Disability Determinations **#300**
PO Box 1000
Frankfort, KY 40602
(800) 928-8050 ext. 4024
The Division of Disability Determinations makes decisions of medical eligibility for disability benefits and Medicare for the Social Security Administration for their Social Security Disability Insurance and Supplemental Security Income programs. Obtaining detailed, complete medical evidence and information on the disability applicant's ability to function and perform work-related activities is vital to the evaluation of claims for disability benefits.

Neurologists, orthopedists, pediatricians, speech/language pathologists, etc are needed. For information, see our representatives.

Doctors Insurance Reciprocal **#122**
PO Box 4880
Glen Allen, VA 23058
(804) 270-5800

Dodson Group **#410**
9201 State Line
Kansas City, MO 64131
(800) 825-3760

Eli Lilly and Company **#336**
4350 Brownsboro Rd Suite 110
Louisville, KY 40207
(502) 893-4518

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Berwyn, PA 19312
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Research Triangle Park, NC 27709
(800) 5-GLAXO5

Health Associates of Kentucky, Inc **#409**
1510 Newtown Pike Suite F
Lexington, KY 40511
(606) 258-2340
Health Associates of Kentucky is a management services organization affiliated with the University of Kentucky. Health Associates owns, develops, affiliates with, and operates medical practices. Health Associates assists physicians in their efforts to enhance the patient-physician encounter and to improve healthcare by providing appropriate and necessary support services from recruitment and staffing to a spectrum of financial and management services. Stop by Health Associates' booth to discuss how your practice might benefit from their MSO services.

Janssen Pharmaceutica **#420**
1125 Trenton-Harbourton
PO Box 200
Titusville, NJ 08560
(800) JANSSEN
Janssen Pharmaceutica will be presenting their featured drugs-Propulsid (Cisapride) and Sporanox (Itraconazole). We would like to invite all guests to visit our booth which we will be displaying our latest information and literature on both Propulsid and Sporanox. We will also have various give-aways for you and your office. Also we will be offering the latest information on our new Janssen Gastro Wellness Program which is the newest program offered to all Gastroesophageal Reflux Disease patients at no cost-the program offers patients educational materials in literature, audio and visual tapes, cookbooks, exercise plans, etc. Also there will be representatives to answer any questions on our new Sporanox pulse paks-the easiest and shortest therapy for onychomycosis.

Jewish Hospital Healthcare Services **#415**
100 E Liberty St #300
Louisville, KY 40202
(502) 568-6655
In support of the medical staff of Jewish Hospital and Jewish Hospital HealthCare Services' network physicians, the Physician/Hospital Development Department offers comprehensive programs to assist the private practice physician in building a practice and managing it effectively. Strategic planning resources are available to enhance the physician's practice in the community.

Kentucky Medical Insurance Company **#214**
& KMA Insurance Agency
303 N Hurstbourne Parkway
Louisville, KY 40222
(502) 339-5700
KMIC and KMA Insurance Agency were founded in 1978 by the Kentucky Medical Association with the goal to provide quality insurance to Kentucky physicians. KMIC and KMA Agency have earned the exclusive endorsement of the KMA since their inception. As the market leader in Kentucky and growing rapidly in neighboring states, KMIC has built a solid reputation as a strong, stable company. In partnership with KMIC, the agency offers a broad array of products and services not only for physicians but also for a diversity of families and individuals.

Kentucky Medical News **#408**
2121 Richmond Rd Suite 204
Lexington, KY 40502
(606) 266-6019

The Kentucky Spine Institute **#306**
125 E Maxwell St Suite 202
Lexington, KY 40508
(606) 255-3758

The Louisville Healthcare Network **#210**
(Audubon, Southwest, and Suburban Hospitals)
9200 Shelbyville Rd Suite 350
Louisville, KY 40222
(502) 326-8362/8321
As a group, the network provides the families of our community with a complete range of advanced diagnostic and treatment services, acute care, outpatient care, educational and wellness programs, and more.

Individually, each hospital provides the nurturing care and attention we all need when we're ill. Together, the hospitals make up a remarkable healthcare resource that puts the benefit of medicine's most sophisticated technology and highly skilled professionals within our reach when we need them most.

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2400 W Lloyd Expressway
Evansville, IN 47721
(812) 429-7343
Mead Johnson Nutritionals welcomes you to KMA. We provide nutritional products for infants, children and adults; and specialty formulas for patients having specific medical nutritional needs. We cordially invite you to visit our exhibit booth to discuss our featured products with our representatives. Featured will be: Enfamil, Enfamil 22, Enfamil AR, Lactofree, Nutramigen, ProSobee, and Boost.

Medical Office System Technology, Inc **#218**
530 W Main St
Louisville, KY 40202
(502) 585-3800
(800) 598-9478
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Fort Wayne, IN 46835
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Merck & Co, Inc **#226**
PO Box 4
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(502) 895-8120

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8105 Village Point Dr
Louisville, KY 40291
(502) 231-4722

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101 Bullitt Lane
Louisville, KY 40252
(502) 329-5000

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New York, NY 10003
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Cincinnati, OH 45249
(800) 850-0176

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Raritan, NJ 08869
(800) 624-2542

Pace Financial Corporation **#419**
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1001 Old Harrods Creek Rd
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(502) 254-2027
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Mechanicsburg, PA 17055
(717) 766-1122
Principal Products/Services: Risk transfer and risk financing for healthcare providers, including liability and workers compensation insurance, risk management consulting and claims management services.

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Louisville, KY 40223
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- To over 280,000 covered patients
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- Managed Care Services
- Medical Practice Services
- Rational Risk Contracting
- Informed Physicians and Staffs

For additional information, please call us at (502) 425-7000.

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Pikeville, KY 41501
(606) 437-3985

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Louisville, KY 40202
(502) 581-3017

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(502) 843-1199
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(502) 239-1718

Roerig (Division of Pfizer) **#437**
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(502) 647-3774

Saint Joseph Hospital **#400**
One Saint Joseph Dr
Lexington, KY 40504
(606) 278-7878

St Mary's Health System **#121**
900 E Oak Hill Ave
Knoxville, TN 37917
(423) 545-8306

Schering Laboratories **#436**
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Owensboro, KY 42303
(502) 688-8384

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4445 Lake Forest Dr, Suite 490
Cincinnati, OH 45242
(513) 733-5354

Taustine Eye Center **#403**
1169 Eastern Parkway #3334
Louisville, KY 40217
(502) 458-9004

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Indianapolis, IN 46216
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(502) 499-9099

Key Pharmaceuticals **#428**
2661 Idlewood Dr
Lexington, KY 40513
(606) 223-0929

Office Management Services, Inc **#237**
The 1000 Building
6200 Dutchmans Lane Suite 207
Louisville, KY 40205
(502) 459-8582

SmithKline Beecham Clinical Laboratories **#305**
2307 Greene Way Circle
Louisville, KY 40220
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Baptist Healthcare System 289

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Financial Architects.....289

KMA Insurance Agency .....Cover III

KY Medical Insurance Company, Inc.....Cover II

Lexington Diagnostic Center .....Cover IV

Medical Protective Co 341

Unlimited Medical Services, LLC 340

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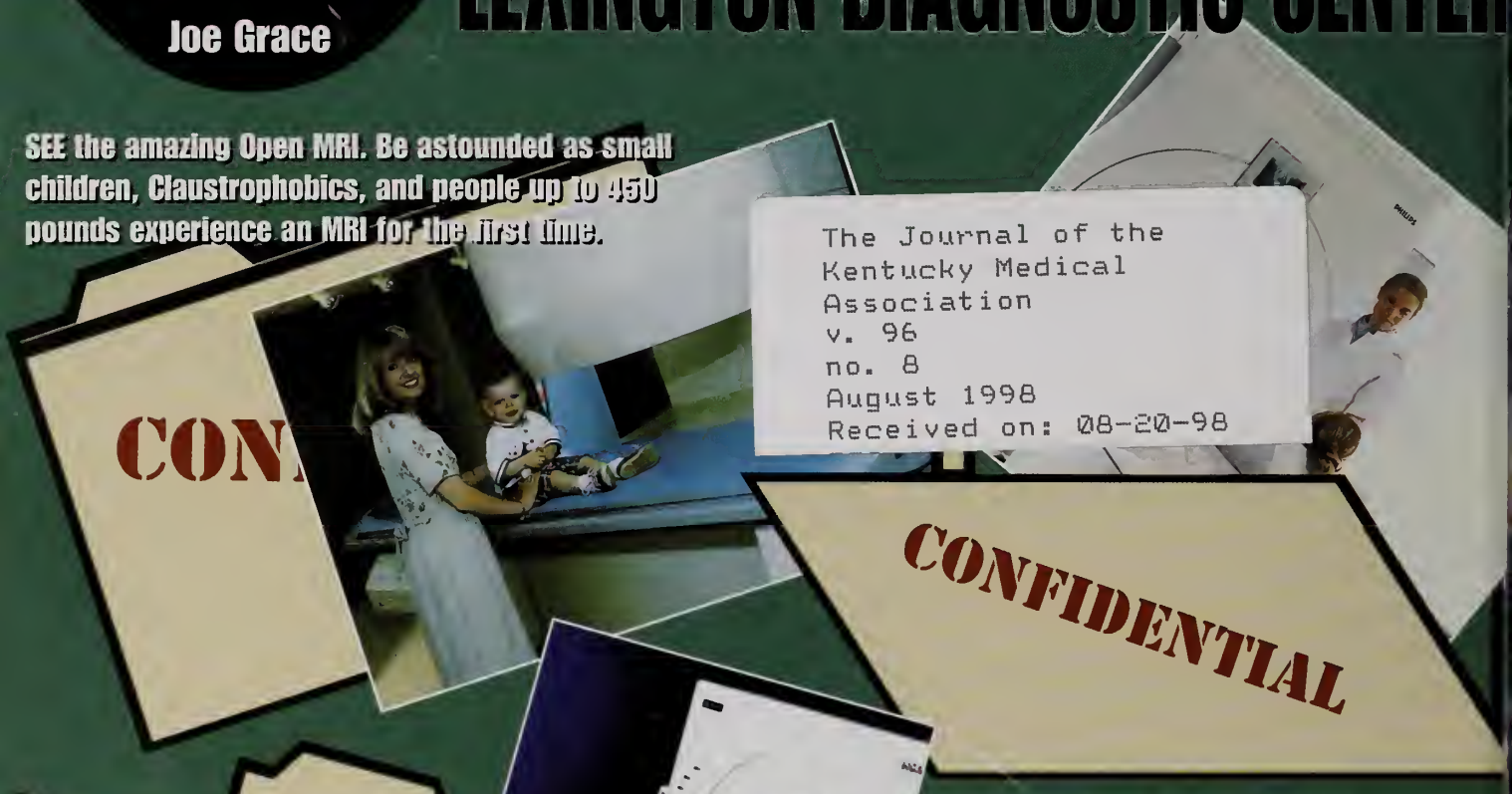
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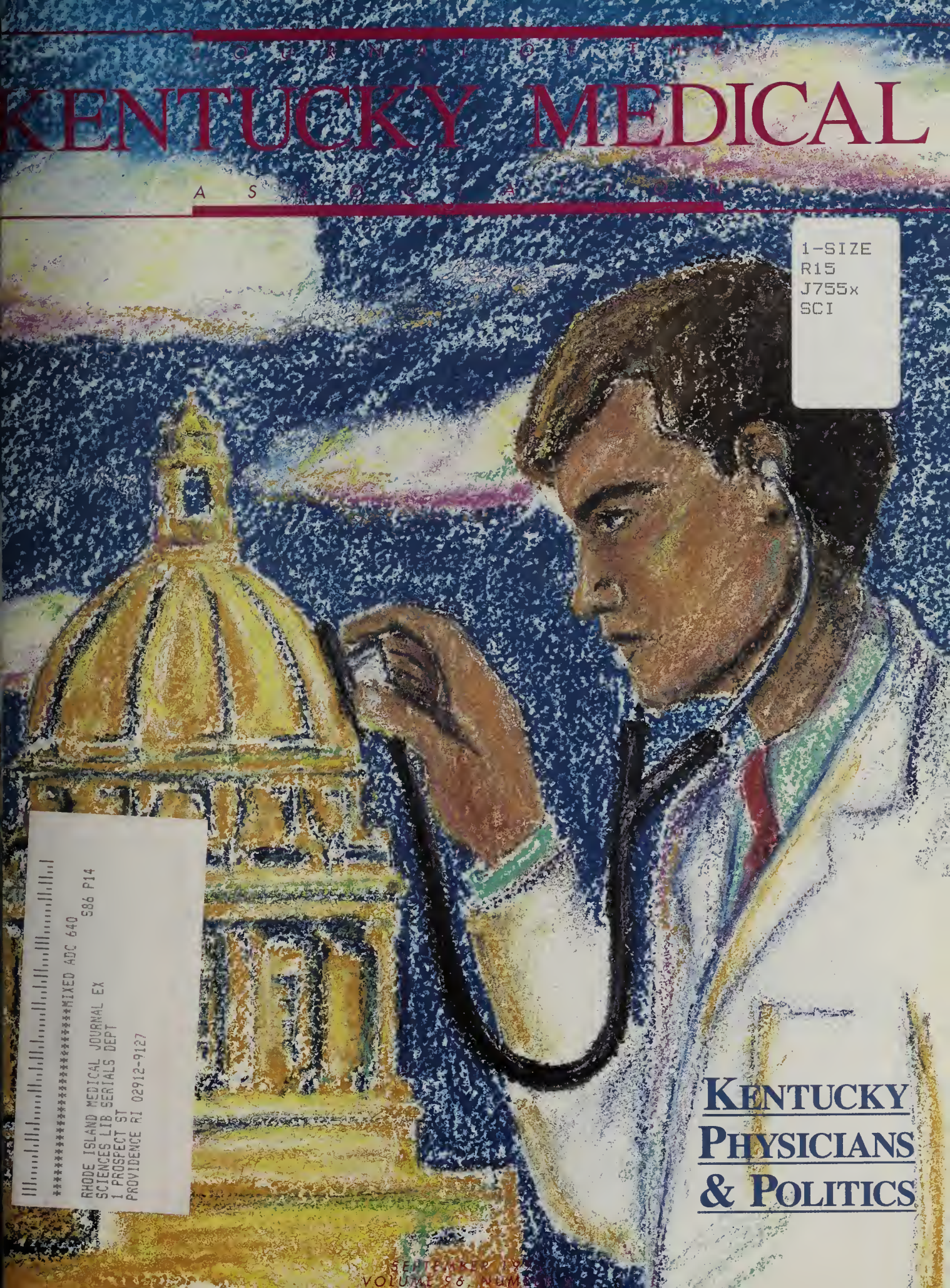
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KENTUCKY PHYSICIANS & POLITICS

SEPTEMBER 19
VOLUME 96 NUM

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For information about the new Women Physicians Congress, call 800 AMA-3211, ext. 4392.

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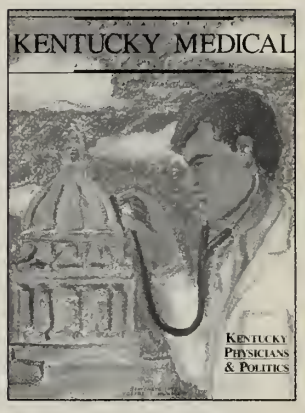
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VOLUME 96, NUMBER 9 SEPTEMBER 1998

COVER STORY	Kentucky Physicians and Politics *William P. VonderHaar, MD; William B. Monnig, MD*	**357**
GRAND ROUNDS	Symptoms, Diagnosis, and Management of Dysphagia *Barbara M. Baker, PhD*	**362**
SPECIAL ARTICLE	Potentially Productive Years of Life Lost (PPYLL) in Kentucky Due to Occupational Fatalities, 1994-1996 *Tim W. Struttman, MSPH; Amy Scheerer, MSPH; Ellyn Moon, MA*	**369**
EDITORIAL	Just a Dot on the Line *Stephen Z. Smith, MD*	**375**
ASSOCIATION	*Monitoring Medicine*	**353**
	U of L Bids Farewell to Health Affairs VP Dr Donald Kmetz	**379**
	. . . and Welcomes Dr Joel Kaplan to Fill the Post	
	KMA Member-Get-a-Member Campaign	**384**
	News	**380**
DEPARTMENTS	President's Page	**351**
	Advertisers' Guide	**385**
	Alliance Page	**377**
	Classifieds	**385**



COVER:
The Kentucky Medical Associatian traditianally ranks as ane af Kentucky's mast pawerful and influential political farces. However, only abaut 19% of Kentucky physicians are KEMPAC members ar contribute to state legislative and Gubernatorial candidates. This manth's caver stary presents a limited study af palitical activity which indicates that a small percentage af physicians participate in the political pracess.

Design and artwork by Lee Wade af Eminence, KY.

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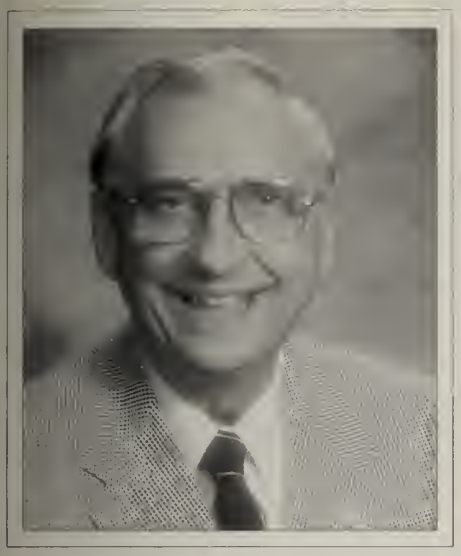
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C. Kenneth Peters, MD

Looking Back to the Past and Forward to the Future

As the Association year winds down and my year as President draws to a close, I thought it appropriate to summarize the high and low points of the year, and reflect somewhat on the future of medicine and the Kentucky Medical Association. Obviously, the highlight of the year occurred when the Kentucky General Assembly adopted House Bill 315, which included KMA's Patient Protection/Provider Fairness legislation. Under the leadership and political astuteness of Representative Bob M. DeWeese MD, and Representative Bob Damron, bolstered by broad support from the Patton Administration and General Assembly leadership, the bill was adopted. However, there were moments when KMA leadership and staff felt powerless as opponents of the insurance provisions threatened to scuttle the entire bill. Fortunately, reason prevailed and through a bipartisan effort the legislation passed. In addition, the 1998 Kentucky General Assembly distinguished itself by defeating numerous proposals that threatened patient care and could have unleashed a slew of charlatans upon the public. As usual, several silly and costly bills passed, headlined by the repeal of the motorcycle helmet law. We grappled throughout the year with the Medicaid Managed Care Project, which has received limited success in the two regions where it is presently operational.

While the General Assembly dominated our agenda for most of the Association year, Kentucky Medical Association officers and staff were quietly working toward the new millennium by developing a strategic plan. We were attempting to develop a road map for the Association's future and provide guidance to officers and staff as medicine transitions to dramatic and unimaginable changes in the coming years. This Association must prepare itself for change and manage the future rather than getting caught in the updraft. While relevancy is a cliché and over utilized, it applies here—for the medical association. Our members' practices are changing overnight, and the perception of this Association by young physicians and the role KMA plays in their lives, is being dramatically altered. Strategic planning requires intense involvement, and demanded a tremendous amount of personal dedication by members of the planning committee. We selected a broad range of individuals, by age, sex, race, practice locale, specialty, urban, rural, academia, etc. In addition, we sought outside opinions from leaders in the political, labor, business, and education communities. Finally, we selected a firm to moderate the planning session and basically educate us on how to accomplish our goals and take us where we wanted to go. The Strategic Planning Group spent an afternoon, night, and the following day at Shakertown, without cell phones, pagers, faxes, and other distractions, and concentrated on the plan at hand. While I won't elaborate on the final product in this article, I will say that this plan indeed provides a roadmap for the Association and gives direction the Association has not previously enjoyed.

While at Shakertown, shock waves swept over the group when the announcement was made that Humana had merged with United to organize the largest HMO in the US. There was both a sadness and alarm within the group planning KMA's future. While Humana had a history of controversy in the physician community, nonetheless they have been excellent corporate citizens. Despite early assurance that everything was rosy, United failed to note the almost $1 billion drop in earnings or losses for the quarter. The failure of this merger appears to point to increasing problems within managed care circles as plans now resort to reducing benefits, denying services, and delaying care to keep stockholders happy. We predicted the outcome at the very outset of managed care. Managed care was oversold and all insiders knew that HMOs were profiting by demanding wholesale reductions from providers. We warned the public and politicians, that sooner or later, physician, hospital and other provider fees and charges would be reduced to the lowest level and managed care and HMOs would be forced to squeeze patients to maintain profits. It happened. Physicians forecasted the effect—the patients squealed, patient protection bills passed in over 30 states, and patient protection has become the single most important national political issue of the day.

This year we attempted to take the KMA throughout Kentucky. In addition to the traditional Trustee meetings, we scheduled regional meetings in Western and Southeastern Kentucky. Our first meeting was held in Owensboro, where we included an afternoon of CME seminars on fraud and abuse and domestic violence. The evening program included several presentations including a legislative report. We scheduled a meeting in Somerset, using a similar agenda. During the year we attended several Trustee meetings which are a high point of any President's year. These meetings provide KMA an opportunity to visit many communities in the state and give local phy-

sicians direct input into KMA policy.

Everyone should have their 15 minutes of fame or "15 minutes in the sun" during their lifetime. For me, that 15 minutes of fame arrived unexpectedly in early August, when the White House and AMA called and requested that I be on a program with the President of the United States to support strong patient protection legislation. I appeared with President Clinton on August 10 in Louisville before a capacity crowd of over 7000 people. My remarks are printed on the following pages of this *Journal*. The AMA has worked diligently for over three years to provide patients and physicians relief from managed care abuses. Even though over 30 states have adopted some form of patient protection, including Kentucky, nonetheless, federal ERISA laws provide HMOs and self insured plans both immunity and special protection from state laws. The ERISA law even provides immunity to HMOs when they make decisions which override physician orders that lead to a patient's death or injury. The KMA joined AMA with a massive campaign to obtain Congressional support for a legislative patient protection legislation sponsored by Democrat leadership and 13 Republicans, including Dr Greg Ganske, an Iowa surgeon and Congressman. Even though the AMA and physicians documented legitimate concerns with the House Bill that eventually passed, Republican leadership led by Speaker Newt Gingrich ignored physician concerns and pushed a bill through that had no hearings or public discussions. Following that gross political demonstration of power, that displayed nothing but disdain for the physicians of this country, AMA and physicians across the country became outraged at House Republicans' total lack of sensitivity toward our patients and the profession. As a result of that action, AMA asked that I appear with the President of the United States in a Patient Protection forum in Louisville. I am pleased to report that we received numerous phone calls and contacts expressing support for our actions—and only one obvious partisan political complaint by a single physician.

This leads me to another area that needs to be addressed. It is no secret that the majority of physicians and spouses are Republicans. We have been core contributors and supporters of the Republican Party for many years. Physicians were Republicans when it was unpopular to be a Republican. Unfortunately, the party many of us supported has now turned its collective back on our patients and the medical profession. Evidently, patients and physicians have become a liability to a party that seems to have developed its own "rainbow coalition" and "cut bait" with folks who have been their traditional allies. This change in direction has occurred on both state and national levels. The 1997 Congressional Budget included increases in reimbursement and services for chiropractors, optometrists, nurse practitioners, and physician assistants. Physicians essentially paid for these increases through additional reimbursement cuts. In addition, Congress "distinguished itself" among the physicians of this country by passing "fraud and abuse" laws that compare favorably with "Gestapo tactics" in their enforcement mechanisms. During the tumultuous 1997 Special Session and the 1998 Session of the Kentucky General Assembly, we constantly wrestled with Republicans, especially in the Senate, over Patient Protection. Their primary concern was singular. Protect out-of-state insurance companies, managed care, and HMOs at all cost. Even our own Bob DeWeese MD, a bedrock conservative, constantly had to spar with his party colleagues to assure that a patient protection bill passed. Evidently, several Republican State Senators think KMA "just got off the boat." They even made hilarious efforts to convince KMA leadership that patient protection legislation should be offered separately from insurance reform. We knew better. The same fate that occurred in Congress would have occurred in Kentucky if we had taken their bait—big business and the Chamber of Commerce would have coalesced with HMOs and insurance companies and killed the legislation. Bob DeWeese, KMA leadership, and our lobbyists immediately rejected that idea as out of hand. Unfortunately, some physicians and spouses "bought that line" from several Republican Senators, hook, line, and sinker. However, we never wavered from our original strategy to include patient protection/provider fairness with insurance reforms. In Congress, every single Kentucky Republican voted for the Gingrich/Hasbert Bill which is nothing more than HMOs and managed care protection.

In the coming days and years, physicians will reassess their political strategy and recognize who the friends of their patients and the profession really are. Your leadership is taking the lead by meeting individually with our elected federal officials and on the state level with Senate and House leadership. Once we complete the round of meetings we will report back to you sometime in the fall.

We need to use the same yardstick to measure Republicans as we do the Democrats. Their votes will provide us that yardstick and we will be reporting on their voting records. Republicans are choosing to side with HMOs and big insurance companies over our patients. Democrats in this state gave us the provider tax and House Bill 250 and we struck back furiously. This is the only language politicians understand.

In closing, allow me to express heartfelt thanks to the Board of Trustees and staff for their outstanding support this year. We have enjoyed an excellent year and made great progress. My successor and classmate, Don Stephens, will be an outstanding President. Dr Stephens has been involved in all of the decisions made this year and is extremely well prepared to take the helm. Finally, Rhoda and I sincerely thank the membership for your encouragement and backing. We would, however, be remiss if we didn't give special thanks to our Jefferson County Medical Society colleagues who supported us throughout a long career and provided the opportunity to serve as President of this great organization.

C. Kenneth Peters, MD
KMA President

NEWS FOR KENTUCKY PHYSICIANS

C. Kenneth Peters Address to the Patient Protection Forum August 10, 1998

As I speak today, I'd like for all of us to envision a sick room with two chairs. In one chair the patient, and the other chair, the patient's physician. Any impediment or barrier to the direction that this physician and patient need to pursue concerning treatment, quality care, or length of life is what our conversation here is all about. Mr President, thank you for your leadership to enact comprehensive Patient Protection legislation. The commission, which you appointed, identified serious problems with the practices of some HMOs and insurance companies. Those recommendations provided the spark and foundation for legislation now pending.



The Courier-Journal

A few weeks ago you hosted a panel of patients and physicians who provided clear and convincing testimony about the need for strong patient protection legislation. We heard from a wife whose husband died prematurely because he was denied access to a specialist. A health benefits manager broke down in tears explaining the painful job of telling patients that their health plan denied coverage of potentially lifesaving treatments. The same thing is happening here in Kentucky. In my own practice I experience the unnecessary delays and denials on almost a daily basis. Just last week I submitted a request by phone to a managed care company for a GI series for a patient. The HMO refused to allow an O/P service in my own building to perform the service and directed the patient to an outpatient center 5 miles away. I called the O/P center and was told that the equipment was inoperable and we would have to wait 3 weeks. After calling back, it was suggested that we wait until the equipment was repaired. I was finally referred to someone, at a 1-800 number who ultimately referred me to another 1-800 number in Chicago. After pleading our case I asked her what she would want for her family in similar circumstances. She finally agreed to pay for one x-ray only. I never met this "lady" and I don't think I want to. So, after 34 minutes they finally allowed the patient to be x-rayed—just 50 feet away—at the same or lower cost. Mr President, our patients are saying "enough is enough."

Health plans are denying payment for medical services that clearly fall within accepted standards of care. No one should have to mount a federal case to get medical care they deserve. There is something terribly wrong when someone without a medical degree, who has not examined the patient, can make life and death decisions, and not be held accountable. The only people in the US with immunity are Foreign Diplomats and HMO Bureaucrats. Patients should have the right to an appeal process when a health plan denies payment for treatment recommended by their physician. A cancer patient receiving chemotherapy should not have to switch doctors in the middle of treatment.

HMOs must be held accountable when they make medical decisions that result in permanent injury or premature deaths. Mr President, I am a husband, a father, a physician, and a Republican. Two weeks ago, however, the House of Representatives passed a patient protection bill that contains serious flaws. Upon careful examination, the bill passed is a step backwards. It undermines patient protections we have already enacted in Kentucky. The house bill is clearly written to protect insurance companies rather than patients. The bill contains an appeal process, but gives health plans complete authority to define what is medically necessary. Other problems include allowing health plans to disclose personal health information without patient consent and charging patients for filing appeal. There is still time for Congress to act. The AMA has endorsed Senate Bill 1890 sponsored by Senator Daschle. Senators Lott and Nickles have also proposed legislation that does not contain some of the serious flaws in the House bill. Some of the patient protections in the Lott-Nickles bill need to be strengthened. Senators Chafee and Graham have also introduced a bipartisan bill to bridge partisan differences.

We cannot allow partisanship to prevent us from doing the right thing for patients. My patients and physician colleagues are concerned that patient protections have become a political football. Providing medical care to sick patients is not a game. I urge everyone here today and patients across the country to contact their Senators and urge them to vote for strong patient protection legislation that President Clinton can sign into law.

KENTUCKY MEDICAL ASSOCIATION CONGRESSIONAL UPDATE

ACTION REQUESTED

Republican Congressmen Ed Whitfield, Ron Lewis, Anne Northup, Jim Bunning, and Hal Rogers voted for H.R. 4250, the Gingrich patient protection legislation. Democrat Congressman Scotty Baesler supported AMA's position by voting for H.R. 3605, a bi-partisan effort supported by Democrats and 13 Republicans, including Rep Greg Ganske (R), a surgeon from Iowa. We urge you to discuss with your Congressmen concerns with H.R. 4250, and seek support for a bipartisan effort to assure "true patient protection." **Contact Senator McConnell and Senator Ford and urge them to oppose H.R. 4250 and support bipartisan Patient Protection legislation** containing the following elements:

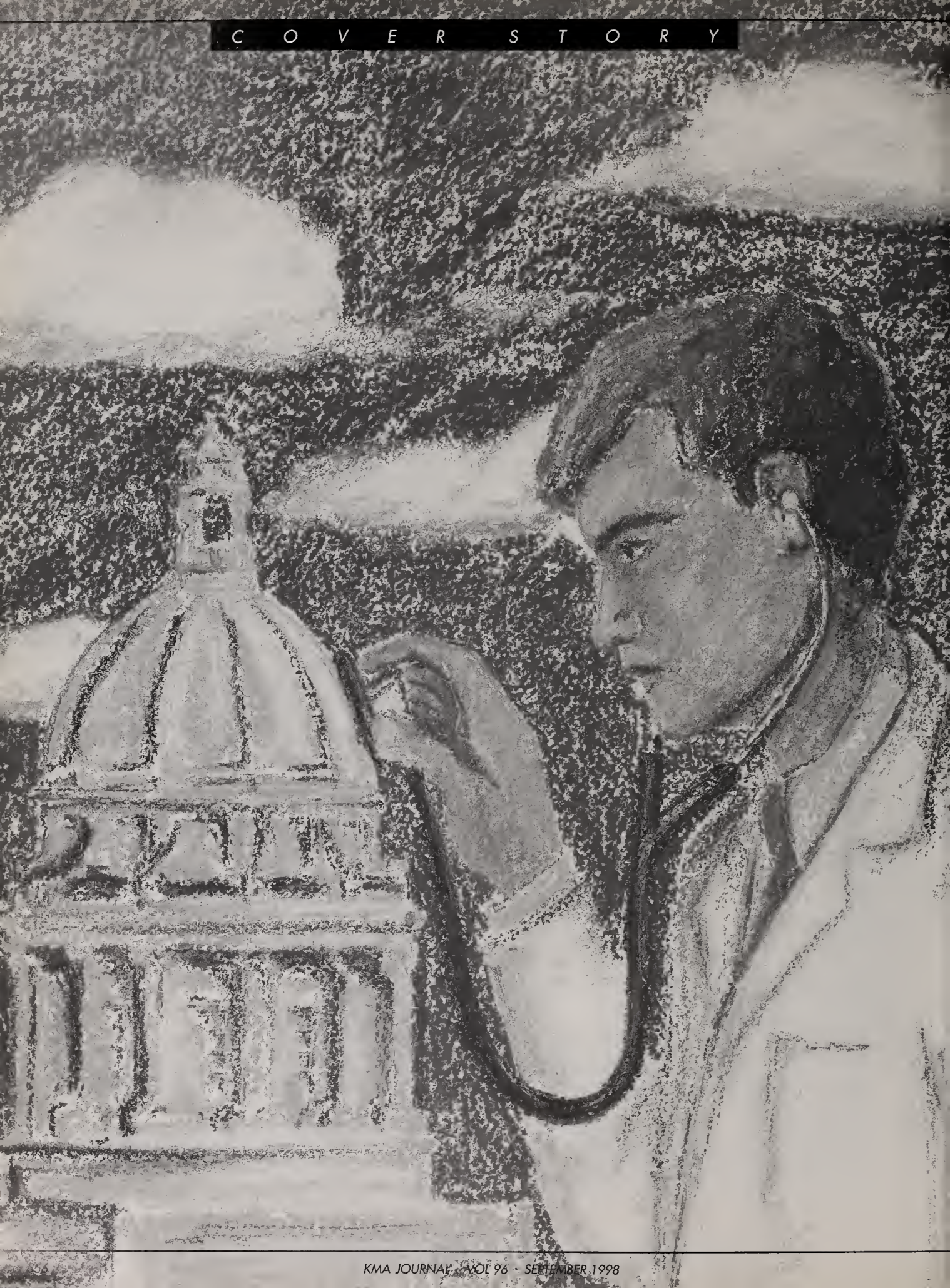
- Full information disclosure detailing what is and is not covered by the plan
- The right to appeal to an independent review board when care is denied
- ERISA health plan accountability for medical decisions
- A prudent layperson definition for emergency services
- Termination of physician gag clauses

Senators Phone numbers and addresses:

Senator Wendell Ford	Senator Mitch McConnell
SR 173A	SR 361A
1st & E Streets NE	1st & E Streets NE
Washington, DC, 20510	Washington, DC 20510

According to AMA, the following discrepancies are prevalent in H.R. 4250

- **Does not end gag clauses**
  The bill prohibits gag clauses **ONLY** on physicians in direct contract with a plan. The majority of physicians contract with plans through medical groups, third party administrators, or other arrangements.
- **Emergency Care**
  The proposal does not define severe pain as an emergency and does not prohibit plans from limiting access to an emergency room outside the plan.
- **External Appeals**
  The legislation makes external appeals advisory only—not binding. Patients would be required to pay a fee, up to $100, to participate in the appeals process. The "plan" is permitted to develop its own definition of medical necessity, making it difficult for enrollees to appeal. The patient would be permitted to appeal HMO decisions to Federal courts.
- **Access to Specialists**
  Does not assure persons with chronic or serious conditions direct access to specialists. There is no requirement that a plan cover non-network specialists, even if the network has insufficient specialists to treat the condition.
- **Insurance Market**
  The provisions do not apply to the individual market, thus leaving the most vulnerable individuals without protection. The bill expands immunity to plans insuring millions, thus prohibiting these additional individuals from seeking redress for injury or death caused by decisions of a health plan.
- **Immunity from liability**
  The ERISA exemption provides "self insured" plans and HMOs immunity for decisions or actions causing injury or death to a patient. Only Foreign Diplomats and HMO bureaucrats enjoy total immunity in the US.
- **Determination of medical necessity**
  The bill locks into federal law requirements that insurance companies, not doctors, determine "medical necessity."
- **Preemption of state legislated patient protections**
  Appears to preempt and turn back the clock on patient protection legislation enacted in over 30 states, including Kentucky.
- **Point of Service**
  Point-of-service option to be offered only if cost is 1% or higher than the cost of the HMO premiums—even though the insured agrees to pay the difference. This effectively precludes any POS provisions.
- **Direct Access to OB/GYN**
  Permits routine OB and well woman services only. All other care requires prior authorization through a primary care physician.



Kentucky Physicians and Politics

William P. VonderHaar, MD; William B. Monnig, MD

The Kentucky Medical Association traditionally ranks as one of Kentucky's most powerful and influential political forces. According to the *Louisville Courier-Journal,* "Physicians have emerged as big players in politics, and make the largest contributions of any occupational group." That political power has made KMA a formidable advocate for patient care and the medical profession. However, despite medicine's traditional influence, in 1994 the Governor and the Kentucky General Assembly (KGA) pushed through a 2% tax on physicians' gross income; enacted House Bill 250 which directed that a government appointed Health Policy Board manage the entire health industry; and reduced physician Medicaid reimbursement by $52 million.

The 1994 Session prompted a review of the KMA's legislative and political agenda. This review led to suggestions about how KMA could be more effective. Both the KMA and KEMPAC Boards instigated an internal evaluation of the Association's legislative and political planning and direction. Just days following adjournment of the 1994 KGA, KMA began making plans to revamp the health system reform bill, repeal the provider tax, and restore Medicaid funding. KMA developed a comprehensive, well funded campaign to educate patients and members of the medical profession.

This coordinated campaign was an enormous and unprecedented undertaking. KMA and KMA Alliance membership participation was crucial, not only to the success of the campaign, but to the survival of the KMA as a powerful political voice in medical and health affairs. In June 1994, the KMA launched a cohesive four-pronged campaign in the public, legislative, legal, and political arenas.

Public

The KMA Public Education Committee worked full time with public relations consultants on various projects such as patient newsletters; factual studies of Medicaid and other health issues; communications with legislators and community leaders; bumper stickers; and appropriate radio and magazine informationals.

Legislative

In the summer of 1994, the KMA Committee on State Legislative Activities (COSLA) developed a legislative strategy which sent teams of physicians and staff throughout Kentucky, conducting meetings in all 15 Trustee Districts. The teams explained the implications of the provider tax, HB 250 Health System Reform, Medicaid cuts, and provided information to physicians for meetings with legislators. COSLA continued the education process throughout 1994 and into the summer of 1995. In the fall of 1995, a final round of 15 District Trustee meetings was held to present KMA's plans and strategy for the 1996 KGA. In addition, legislative packets were distributed to members and spouses.

Legal

KMA initiated a legal challenge to the provider tax in Kentucky Courts which eventually wound its way to the Kentucky Supreme Court. That decision was appealed in the federal court system where it ultimately made its way to the US Supreme Court. In addition, KMA also filed suit in Federal Court protesting the illegal reimbursement reductions in Medicaid.

Political

On the political front, KEMPAC instituted a membership drive and strongly supported legislators who voted against the provider tax and HB 250. KEMPAC, with the support of the KMA Alliance, launched a voter registration drive; provided physicians and spouses the opportunity to attend seminars to learn how to organize and manage a campaign; initiated access to a nationally recognized candidate school; and provided information on effective participation in campaigns. In addition, the Board voted to financially support physicians and spouses, who at the time of their announce-

William P. Vanderhaar, MD, is immediote Past Chair af KEMPAC. Dr Vanderhaar is a fomily physician in Louisville. He is a Past President of the Jeffersan Caunty Medicol Saciety and serves as Secretary-Treasurer af the KMA.

William B. Monnig, MD, is Choir af KEMPAC. Dr Mannig is a urolagist in Edgewaod and serves as Alternate Delegate to the AMA. He is a Past President af the KMA, and served three terms as Chair af the KMA Board af Trustees.

Table 1. Stote Legislative Roces

Yeor	# Physicians	Amaunt	Percentage Cantributing
1994	347	$155,677	6%
1996	254	$130,737	4%

Table 2. 1995 Gubernatariol Compoign

Cantributars	Totol Contributians	% Participatian	Average Cantributian
640	$202,772	11%	$317

Table 3. 1995 Governor Electian

Candidote	Totol Cantributians*	Physicion Cantributors
Fargy	$131,792	425
Pattan	51,344	156
Rase	9,572	28
Babboge	8,991	27
Gable	1,073	4
TOTALS	$202,772	640

*Partians estimated

Table 4. Specialty Participatian — 1994 Legislative/1995 Gubernotoriol Compoign

Speciolty	% Participatian	# Participating	Avg Contributors	Tatol
Allergy/Immunalogy	20	8	287	$ 2,299
Anesthesialogy	12	46	329	15,150
Cordiology	17	30	858	19,750
Colan-Rectal	8	1	600	600
Critical Core	50	2	500	1,000
Dermatalagy	15	12	271	3,250
Emergency	6	14	400	5,600
Endacrinalogy	3	1	1,200	1,200
Family Proctice	11	97	494	47,877
Gostroenterology	17	14	533	7,468
Generol Proctice	9	19	296	5,685
Generol Surgery	17	74	424	31,408
Gynecalagy Oncalagy	14	1	150	150
Hematalagy	8	3	342	1,025
Infectiaus Disease	11	2	275	550
Internal Medicine	12	52	288	14,985
Nephralagy	9	4	665	2,661
Neuralagy	9	8	489	3,910
Neurasurgery	29	16	567	9,075
OBGYN	15	54	583	31,466
Oncalagy	8	3	213	640
Ophtholmology	31	56	392	21,952
Orthopedics	29	65	644	41,833
Otaloryngolagy	31	25	574	14,355
Pathalogy	10	17	431	7,325
Pediatrics	4	10	314	5,960
Physical Med & Rehob	12	4	455	1,775
Plostic Surgery	21	15	592	8,875
Preventive Medicine	5	1	500	500
Psychiotry	4	14	321	4,500
Pulmonory	13	7	279	1,950
Radiology	16	53	532	27,675
Repraductive Enda	22	2	500	1,000
Rheumotalogy	11	3	550	1,650
Thorocic Surgery	15	9	367	3,300
Urology	21	22	457	10,050

ment for state and national legislative offices are members of KMA and KEMPAC/AMPAC.

Results of Campaign

In 1996, with the Governor's support, the KGA began a phase-out of the provider tax; repealed onerous sections of HB 250; approved settling the $52 million lawsuit; and restored Medicaid reimbursement. The crowning point of the entire campaign occurred when two physician Senators, two physician House members, and a physician Lt Governor negotiated the final legislative product that repealed major portions of HB 250. The largest and most highly successful public, legislative, legal, and political campaign in KMA's history came to a close.

Purpose of Study

Based on intense feelings within the physician community following passage of the provider tax, HB 250, and Medicaid cuts, KEMPAC sought to determine if punitive legislation generated political activity within the physician community. In addition, KEMPAC sought to measure physician participation in the political process over a period of years. Information in this report is based upon 1994 and 1996 KGA elections and the 1995 gubernatorial campaign (Tables 1-3). The data was obtained from Kentucky Registry of Election Finance reports and annual KMA and KEMPAC membership studies. Specialty designations are based upon physician declaration of specialty to the Kentucky Board of Medical Licensure (Table 4).

1994 Kentucky General Assembly Elections

- 5915 practicing physicians.
- 347 physicians contributed $155,677 to General Assembly candidates.
- 216 of 347 contributions (62%) went to 17 of 119 races.
- $48,530 or 31% of total physician contributions were concentrated in three districts where physicians were candidates. (Doctors Crase, Fletcher, Kafoglis) (Table 5)
- 6% of practicing physicians contributed.
- Average contribution was $449.
- Average contribution among all 5915 physicians was $26.
- Physicians in 71 of 120 counties contributed.
- Physicians participated in 63 of 119 legislative races. (100 House, 19 Senate)

1995 Gubernatorial Elections

- 6055 practicing physicians.
- 640 physicians contributed $202,772 to Gubernatorial Candidates.
- 11% of practicing physicians contributed.
- Average contribution was $317.
- Average contribution among all 6055 practicing physicians was $33.
- Physicians in 67 of 120 counties contributed.
- Physicians contributed to all 5 candidate campaigns.

1996 Kentucky General Assembly Elections

- 6335 practicing physicians.
- 254 physicians contributed $130,737 to General Assembly candidates.
- 133 of 254 contributions (52%) went to 9 of 119 races.
- $17,475 or 13% of physician contributions were concentrated in three districts where physicians were candidates. (Doctors DeWeese, Hulsman, Prunty) (Table 5)
- 4% of practicing physicians contributed.
- Average contribution was $515.
- Average contribution among all 6335 physicians was $21.
- Physicians in 46 of 120 counties contributed.
- Physicians participated in 39 of 119 legislative races. (100 House, 19 Senate)

KEMPAC

KEMPAC contributes to State Representatives and State Senators and contributions are limited by law to $1000 per election.

- In 1994 KEMPAC had 1076 members, or 18% of practicing physicians.
- In 1994 KEMPAC contributed $27,300 to state legislative candidates.
- In 1994 KEMPAC contributions represented 15% of total physician contributions to state legislative candidates. (Note: In 1994 KEMPAC supported candidate incumbents who voted against the provider tax or HB 250).
- In 1995 KEMPAC had 1012 members, or 17% of practicing physicians. (There were no state legislative races in 1995).
- In 1996 KEMPAC had 1089 members, or 17% of practicing physicians.
- KEMPAC contributed $72,900 to state legislative candidates in 1996.
- In 1996 KEMPAC contributions represented 38% of total physician contributions to state legislative candidates.

Additional Facts

- Over a 3 year period, Kentucky physicians averaged contributing $27 annually to state legislative and gubernatorial candidates.
- In 1994, 64 physician spouses contributed $21,061 to legislative races, and 69 spouses contributed $23,734 to gubernatorial candidates in 1995.
- In 1996, 28% of physician contributions were made in four races in Northern Kentucky.
- Kentucky Election Finance Reports indicated that 36 Physician Specialists/Subspecialists contributed to 1994 and 1995 campaigns.
- 30% of KEMPAC members also contributed directly to legislative and gubernatorial candidates in 1994 and 1995.
- 19% of Kentucky physicians participate in the legislative/political process either through direct contributions or by belonging to KEMPAC.
- According to the *Louisville Courier-Journal*, physicians have emerged as big players in politics, and make the largest contributions of any occupational group, even outpacing labor PACs.
- The *Courier-Journal* reported that Kentucky physicians and their employees contributed $315,243 in 1996 state and local political races.
- Physicians in 77 of 120 counties belong to KEMPAC.
- Kentucky Election Finance reported in 1994 that Democrat State Legislative Candidates raised $2,336,105, while their Republican counterparts raised $1,613,376.

Table 5. Top 5 Legislative Campaigns in which Physicians Contributed

1994			
City	Candidates	# Physician Contributors	Amount
Somerset	James Crase MD et al	87	$24,515
Bowling Green	Nicholas Kafoglis MD/Hughes	40	13,200
Lexington	Ernie Fletcher MD/Buckley	35	10,673
Verona	Gex Williams/Cain	29	9,500
Ashland	Charles Borders/Allen	40	8,400

1996			
City	Candidates	# Physician Contributors	Amount
Erlanger	Jack Westwood/Meyer	43	$21,674
Hindman	Benny Bailey/Preston	38	15,600
Louisville	Bob DeWeese MD/Lohman	29	9,750
Louisville	Susan Johns/Phil Hulsman MD	23	7,300
Florence	Charlie Walton/Hoffman	11	5,450

Note: Physician contributors only

Summary

Approximately 19% of Kentucky Physicians are KEMPAC members or contribute to state legislative and Gubernatorial candidates. This limited study of political activity indicates that a small percentage of physicians participate in the political process. Despite the small number of contributors to state legislative candidates, KMA's legislative and lobbying effort is highly effective and members receive high quality service and representation in the political arena.

Whatever your politics—join KEMPAC for representation in Washington and Frankfort!

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The Kentucky Educational Medical Poltical Action Committee (KEMPAC) is the political arm of the Kentucky Medical Association. KEMPAC receives its funds through its members' dues and these funds are then used to support political candidates. KEMPAC shares fundraising with AMPAC (American Medical Political Action Committee). When a physicians pays dues of $100, one-half of those dues ($50) go to AMPAC for support of federal candidates who share medicine's views.

Is KEMPAC affiliated with any Political Party?

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If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to suggested amount. Neither the AMA or the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. A portion of the voluntary contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions to KEMPAC and AMPAC are not deductible as charitable contributions for Federal Income Tax Purposes.

Symptoms, Diagnosis, and Management of Dysphagia

Barbara M. Baker, PhD

From the Division of Communicative Disorders, Department of Surgery, University of Louisville School of Medicine, Louisville, KY.

Persons with swallowing difficulty may develop a variety of clinical symptoms resulting from anatomic and/or physiologic abnormalities that will produce predictable swallowing dysfunction. Complaints can vary from vocal quality changes, which include hypernasal voice, hoarseness and breathiness, a wet, gurgling tone, and reduced pitch range, to changes in respiratory rate, poor oral bolus manipulation, food or liquid aspiration, food that sticks or backs up in the throat, nasal regurgitation, or lack of awareness of aspirated material that may lead to recurring aspiration pneumonia. Various evaluation techniques can be used to detect the cause of the swallowing disorder which, in turn, dictates management strategies such as alternative by-pass supplementation, diet and liquid consistency considerations, and therapeutic intervention. The purpose of this article is to review the various evaluation protocols and treatment options for specific dysphagic symptoms.

Clinical Evaluation

The examination for dysphagia usually begins with a bedside or clinical evaluation. The patient is asked to swallow three different substances, which usually include a cracker or hard cookie or a particular food identified by the patient as difficult to swallow; a pureed food such as applesauce, pudding, or mashed potatoes; and liquids that vary from thin to thick. Commercially-prepared thickening agents can be used in the liquids to obtain the desired consistency. Patients with tracheostomy undergo an additional procedure where blue dye is added to the food to aid in detecting aspiration through a tracheostomy tube.[1] The clinical/bedside examination is limited in diagnostic significance because it can provide evidence of aspiration only if the patient has adequate sensation and produces the expected choking or coughing. Wet, gurgling vocal quality will signal that residue is penetrating the laryngeal vestibule, with collection of the material remaining on the vocal cords. However, the cause of the swallowing dysfunction may be determined only after an examination at the bedside or in the office; it is not enough to determine whether the patient is aspirating. The next step in the evaluation is to identify which phase of the swallowing sequence is impaired, so the clinician can develop treatment strategies.

The Normal Swallow

The swallowing sequence is divided into oral preparation, and oral, pharyngeal, and esophageal phases (Figure 1).[2] Each phase has specific components that initiate and terminate it, and each may be evaluated separately for anatomical and physiological abnormalities. Oral preparation consists of the maneuvers necessary for tasting the food, manipulating it with the teeth and tongue, and forming the bolus on the hard palate. The oral phase consists of the tongue moving the food in a posterior direction, accompanied by the velum pulling forward to keep the food in the oral cavity, where the swallow reflex is being activated at the faucial pillars. The strength of the tongue is the single most important aspect of the oral phase of the swallow, since weakness or surgical alteration will decrease or negate activation of the swallowing reflex, which in turn may contribute to premature spillage over the base of the tongue and lead to aspiration. The pharyngeal phase follows the activation of the swallow reflex and terminates at the cervical esophageal sphincter. During this phase, food is squeezed through the pharynx by way of the valleculae and pyriform sinuses. Food remaining in these areas can be aspirated before, during, or after swallowing has occurred. Poor epiglottis protection of the airway, poor laryngeal elevation and weak or paralyzed vocal cords can lead to aspiration during swallowing. The esophageal phase of the swallow is from the level of the cricopharyngeal muscle to the stomach. Oral-pharyngeal dysphagia of this area may be due to a cricopharyngeal tightening or spasm, which will give the

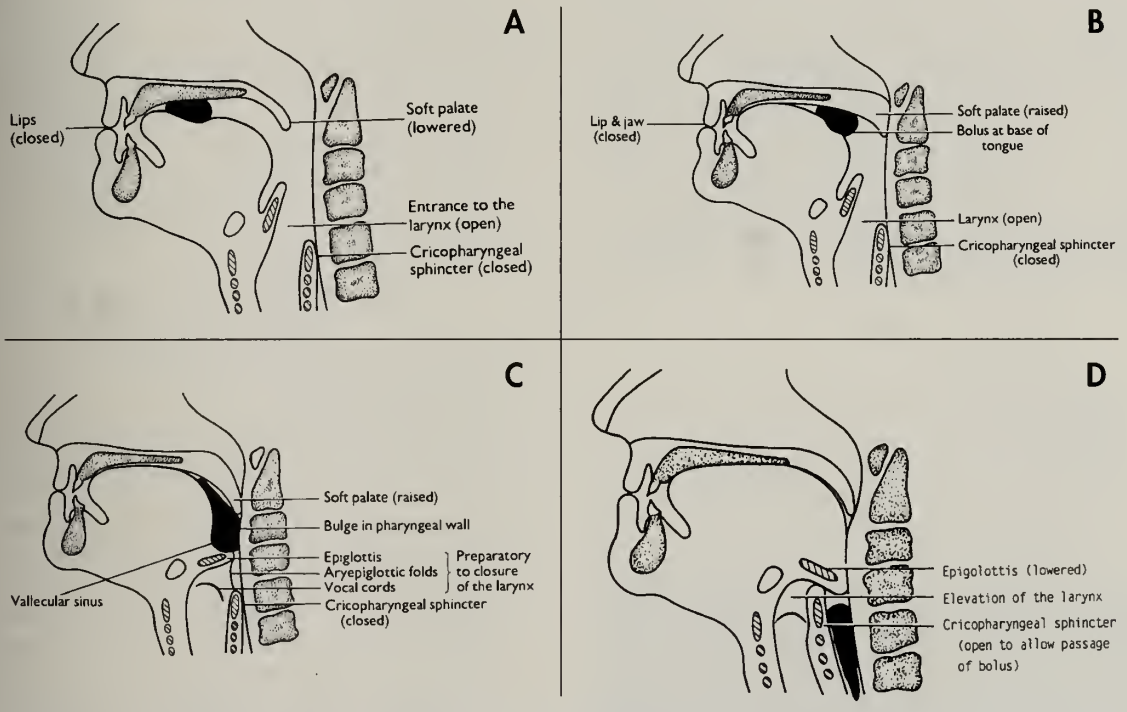


Figure 1 — The swallowing sequence (A)Positions of the oral and other structures in the preparatory phase of the oral stage. (B) Positions of the oral and other structures at the end of the oral stage before the bolus is projected into the pharynx. (C) Position of the bolus immediately prior to the elevation of the larynx. (D) The bolus passing through the relaxed cricopharyngeal sphincter, with the airway protected. (Reproduced with permission from Langley[2])

patient the feeling that food is stuck in the thoracic area. Lower esophageal dysfunction, such as poor esophageal motility or reflux esophagitis, will not be addressed in this article.

Dysphagia may be associated with various medical disorders, most typically stroke, closed head injury, degenerative disease processes, head and neck cancer, ventilator dependency, and vocal cord paresis or paralysis. A weakness of the musculature or surgical alteration of the structures will contribute to dysphagia and should be evaluated to determine which phase of swallowing is impaired. This can be done by the "gold standard" fluoroscopy procedure known as a modified barium swallow[3] or by relatively new procedures, fiberscopic endoscopic evaluation of swallowing (FEES)[4] and fiberoptic endoscopic evaluation of swallowing with sensory testing (FEEST).[5]

Modified Barium Swallow

The modified barium swallow differs from the typical barium swallow in the following ways: (1) the patient is either standing or positioned in a specialized chair placed between the video fluoroscopic equipment and the table, which is upright; (2) several barium consistencies, rather than a cup of liquid barium, are given to test for tolerance of various diet textures; (3) the focus of the study is on the oral, pharyngeal, and cervical esophageal anatomic areas; and (4) the bolus is not followed fluoroscopically through the esophagus to the stomach. Prior to the procedure, a thorough history of pulmonary, esophageal, neurological, and structural alteration symptoms and complaints are elicited. A complete oral mechanism examination is conducted before the procedure to assess structural alterations and physiological abnormalities contributing to dysphagia. The patient is initially positioned for a lateral view of the structures of the oral cavity, pharynx, and cervical esophagus, and is repositioned for the anterior-posterior view, which aids in assessment of unilateral versus bilateral impairment and the amount of stasis in the valleculae and pyriform sinuses.

Table 1. Food categories

Category	Examples
Liquids	Apple juice, soda pop, water
Thick liquids	Apricot nectar, tomato juice, milk shakes
Ultra-thick liquids	Custard, yogurt, pudding
Formable (type A) solids	Soft cookies, mashed potatoes, puree
Particulate (type B) solids	Deviled chicken, hamburger
Multi-textured (type C) solids	Beef stew, spaghetti with meatballs

(Reproduced with permission from Palmer et al[6])

The procedure begins with the patient consuming consistencies that he or she can tolerate and progresses to thicker consistencies. Some clinicians will begin with the most difficult-to-swallow consistency, depending on the patient's complaint. The consistencies used are: (1) thin liquid barium; (2) nectar-thick barium; (3) honey-thick barium; (4) esophatrast paste to represent a pureed consistency; (5) soft items such as a banana coated with barium paste; and (6) solid substances such as crackers, hard cookies, or meat coated with barium paste. Substances are administered on a spoon, through a straw, or from a cup, depending on the swallowing capabilities of the patient. Each consistency is administered twice and viewed in the lateral and anterior-posterior planes.[1] The clinician will give varying amounts of the substances, from small to increasingly larger amounts, intended to stress the swallowing mechanism. This is important because it helps determine whether aspiration occurs and under what conditions. An individual may not aspirate small amounts of controlled substances. However, aspiration may occur with larger amounts of various consistencies.

At the end of the procedure, the clinician will determine the cause of the dysphagia, prescribe a diet and develop treatment strategies. For example, if a unilateral weakness is present, the patient will be asked to assume head and/or chin positions while he or she is undergoing videofluoroscopy. This will aid in determining whether a head turn or chin tuck will block the patient's weak side and, in turn, direct the food to the stronger side, thus using a compensatory strategy to prevent aspiration. The purpose of a modified barium swallow is not only to determine whether aspiration is occurring, but more appropriately, to detect aspiration and determine which phase of the swallowing sequence is impaired. It is also used to prescribe a safe diet and proper liquid consistency. Each patient requires an individualized treatment program.

For example, not all patients can tolerate thin liquids (Table 1).[6] Individuals with oral motor weakness or delayed or absent swallow reflex will aspirate thin liquids because they cannot control the bolus and the subsequent splashing into the unprotected airway. Such patients would be given thickened liquids and possibly a pureed diet. However, individuals with intact oral and pharyngeal phases of swallowing who have cricopharyngeal dysfunction can tolerate thin liquids, yet have difficulty with thickened substances.

Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

Recently, FEES has been used to evaluate swallowing. This procedure utilizes the nasopharyngoscope typically used by otolaryngologists to examine the nasopharynx and the vocal cords. It is suggested for patients facing immediate discharge from the hospital; those with severe contracture; those who are minimally alert, in intensive care units or on ventilators/respirators; who are restrained, or are in nursing homes and without access to fluoroscopy.[7]

The patient is given various food consistencies and the swallowing process is viewed through the endoscope. Patients are examined in their typical eating positions. Ambulatory patients are examined while they are upright, while bedridden patients are examined at the bedside, with the head of their bed elevated 45 degrees. The scope is passed just behind the inferior turbinate in the inferior meatus (Figure 2).[8] With the scope in the nasopharynx, the velopharyngeal port can be viewed. The tip of the scope is then passed downward and into the oropharynx. The pharynx is visualized. Next the scope is passed to a point posterior to the epiglottis, where the general appearance of the laryngeal structures can be visualized (Figure 3). The patient is asked to dry swallow, hold his or her breath, cough, and phonate, all of which permits assessment of vocal fold adduction adequacy.

The swallowing evaluation consists of introducing measured quantities of food and liquid for the patient to swallow. All food consistencies are coated with green dye. The actual foods used are skim milk, applesauce, and bread and cheese. Aspiration before the swallow, secondary to premature spillage into the hypopharynx, and aspiration after the swallow, secondary to pharyngeal residue can be observed. Aspiration that occurs during the swallow can usually be identified by material remaining in the airway.

If aspiration or penetration occurs during the

FEES procedure without response from the patient, such as coughing or clearing the throat, the evaluation is usually terminated and the patient's condition is diagnosed as a silent aspiration. However, even if no penetration or aspiration occurs during the swallow study, it does not always assure that the patient will never aspirate, since the procedure evaluates only a limited number of swallows and a small amount of food.

Fiberoptic Evaluation of Swallowing with Sensory Testing (FEEST)

Sensitivity of the laryngeal region is tested by FEEST,[5] which will predict the patient's ability to respond to potential aspiration. The tip of the scope is deflected to lightly probe the pharyngeal walls, the laryngeal surface of the epiglottis, the aryepiglottic folds, the arytenoid, and the vocal cords to determine sensitivity. Patients who are insensitive to the probe are presumed to be insensitive to food or liquid. In 1996, Aviv and co-workers,[9] developed an alternative and quantifiable method to test stroke patients with dysphagia whereby air pulse stimuli are delivered via a flexible fiberoptic telescope to the mucosa (Figure 4). A

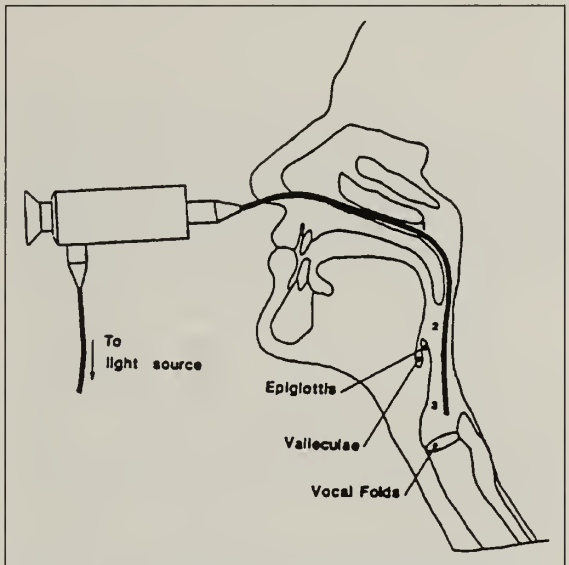


Figure 2 — Properly positioned endoscope for assessment of swallowing. (Reproduced with permission from Langmore et al[5])



Figure 4 — Air puff triggering mechanism. (Reproduced with permission from Aviv et al[7])

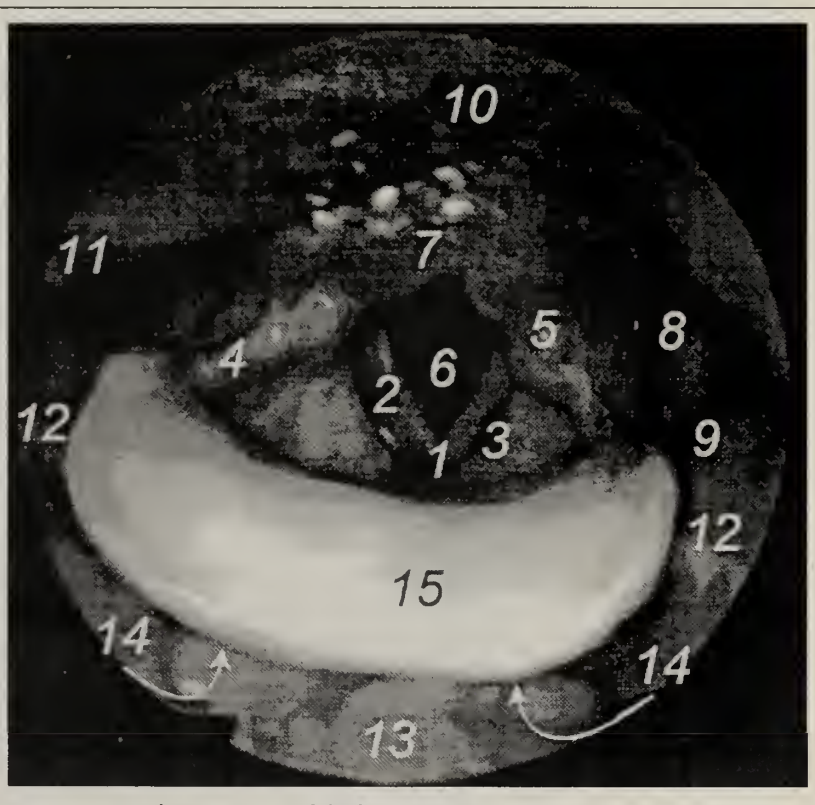


Figure 3 — Endoscopic view of the larynx.
**1 — anterior commisure; 2 — true vocal cord; 3 — false vocal cord; 4 — arepiglottic fold; 5 — arytenoid; 6 — cricothyroid membrane (subglottic shelf); 7 — interarytenoid space; 8 — pyriform sinus; 9 — pyriform fossa (lateral channel); 10 — posterior pharyngeal wall; 11 — lateral pharyngeal wall; 12 — pharyngeoepiglottic band; 13 — base of tongue; 14 — vallecular space; 15 — epiglottis. (Reproduced with permission from Langmore et al[10])*

pressure- and duration-controlled puff of air is delivered to the anterior wall of the pyriform sinus. The air is obtained from a standard air pump and ejected from an internal port located within a flexible fiberoptic laryngoscope. Both the right and left sides of the pharynx and the supraglottic larynx are tested. The examination lasts approximately 10 minutes.

Langmore[10] compared the "gold standard" modified barium swallow video fluoroscopic procedure to the endoscopic FEEST procedure by indicating the advantages and application of each procedure (Table 2). The modified barium swallow procedure allows a view of the oral cavity and esophagus, while the endoscopic procedure affords a direct view of the valleculae, pyriform sinuses, vocal cords, and trachea.

Patients' complaints or symptoms can be correlated with their anatomic or physiologic dysfunction. For example, a hypernasal voice can be due to incomplete velopharyngeal closure that leads to nasal regurgitation. A hoarse or breathy voice can be caused by incomplete true vocal cord adduction, vocal cord paralysis, or bowed vocal cords, which may result in penetration or aspiration before or during swallowing, with ineffective coughing or throat-clearing. Wet voice quality can be caused by secretions pooling in the laryngeal vestibule, which will be aspirated after the swallow.

Treatment Strategies

When the cause and diagnosis of a patient's dysphagia are established, therapy strategies and diet considerations are the next phase of treatment. The clinician will determine bolus consistency, bolus size, and the patient's ability to perform the required tasks and cooperate with the step-by-step therapy instructions. Following are therapeutic maneuvers used to assess their effect on the swallow: Postural changes such as the chin tuck, which widens the valleculae and allows food to remain there while the patient finally initiates a delayed swallow reflex. A head turn to the left or right will block the weak side and deflect food down the strong side. A purposeful breath hold using the supraglottic swallow technique will aid the patient in clearing a compromised airway. The Mendelsohn maneuver promotes prolonged laryngeal elevation. Multiple

Table 2. Findings thot ore better reveoled endoscopicolly ond fluoroscapically

Endascapically	Fluoroscopicolly
Anatomic relatians; alteratians in anatamy	Tangue contoinment, mosticotion of the bolus
Effect of feeding tube an anatamy and swallawing	Tangue propulsion ot onset of swollow
Velapharyngeal clasure; nasol reflux	Arytenaid cantact ta epiglottis during swollow
Frequency af spantoneous or dry swollows	Completeness af epiglattic retroflexion during swollow
Status of secretions; obility to sense, swollow or cleor secretions	Hyoid elevotion
Loryngeol activity for respiratian; effect of respirotory prablems an swallaw	Loryngeol elevotion
Loryngeol airway pratectian	Cricophoryngeol opening
Phoryngeal/laryngeal sensitivity	Airway closure ot level of orytenoid ta epiglattal contoct
Stotus of airway during balus spilloge (before the swollow)	Aspiratian during the height of swollaw
Locotion of spillage; penetrotion of spilloge	Esophageal clearance
Vocol fold/arytenaid mavement ot onset of swollow	Gostroesaphageal reflux
Amount, locotian af residue after swollow	Ability to produce effortful swollow ond Mendelsahn moneuver
Residue build-up, patient response to residue	
Aspiration of residue after swollow	
Fatigue over o meol, passibly leoding ta aspiratian	
Effectiveness af postural change to olter poth af bolus flow	
Ability to hold breath volitionally ar sustoin breath	
Effect af different balus consistencies, temperatures, ond taste an the swallaw	
Esophageal-ta-phorynx reflux	

(Repraduced with permission fram Langmore et al[10])

swallows help to strip the valleculae or pharyngeal/esophageal areas. The mechanism of bolus delivery must be factored in decisions about appropriate bite size, consistency of solids and liquids, temperature and taste, rate of food delivery, and method of delivery such as spoon, straw, or cup. A decision must be made whether the patient can alternate liquids and solids or if solid consistencies can only be taken without a thin liquid, which may facilitate aspiration of the solid substance into the airway. Oral motor exercises may be undertaken to strengthen the lips and the tongue. Thermal stimulation is used to increase a delayed swallow reflex. A 00 laryngeal mirror is placed in ice chips for several seconds and then stroked against the faucial pillars five times on each side. Cold water is then given in small controlled amounts to hasten the swallow reflex. Laryngeal adduction exercises using pushing and pulling techniques help to increase laryngeal closure. Extensive therapy techniques are designed to either strengthen weakened oral and/or pharyngeal structures or aid in developing strategies to compensate for an alteration in the normal swallowing sequence.

Diet considerations are determined from bedside evaluation, modified barium swallow procedure, or FEES testing. Patients with oral phase dysfunction will probably have difficulty masticating solid foods or possibly manipulating pureed foods. Patients with premature spillage have the most difficulty with thin liquids, and liquids that are nectar-thick or honey-thick may be recommended. Individuals with difficult pharyngeal or esophageal peristalsis may need a pureed diet, with thin liquid added to facilitate esophageal transit. Each patient's swallowing difficulty is specific to the anatomic and physiologic considerations found on evaluation. Therefore, a tailor-made therapy plan and therapeutic diet are essential.

References

1. O'Sullivan N. *Dysphagia care team approach.* Los Angeles, CA: Cottage Square Publishers; 1990.
2. Langley J. Working with swallowing disorders. In: Darvill GC ed. *The Normal Swallow.* Bicester UK: Winslow Press; 1989:76-85.
3. Logeman JA. *Evaluation of swallowing disorders.* San Diego, CA: College Hill Press; 1983.
4. Logeman JA. *Manual for the videoflurographic study of swallowing.* San Diego, CA: College Hill Press; 1986.
5. Langmore SE, Schatz K, Olson N. Fiberoptic endoscopic examination of swallowing safety: A new procedure. *Dysphagia.* 1988;2:216-219.
6. Palmer JB, Kuhlemeier KV, Tippett DC, Lynch C. A protocol for the videoflurographic swallowing study. *Dysphagia.* 1993; 8:209-214.
7. Aviv JE, Martin JH, Keen MS, Debell M, Blitzer A. Air pulse quantification of supraglottic and pharyngeal sensation: A new technique. *Ann Otol Rhinol Laryngol.* 1993;102:777-780.
8. Langmore SE, Schatz K, Olson N. Endoscopic and videofluoroscopic evaluations of swallowing and aspiration. *Ann Otol Rhinol Laryngol.* 1991;100:678-681.
9. Aviv JE, Martin JH, Socco RL, et al. Supraglottic and pharyngeal sensory abnormalities in stroke patients with dysphagia. *Ann Otol Rhinol Laryngol.* 1996;105:92-97.
10. Langmore SE. The normal swallow: Endoscopy vs fluoroscopy. Endoscopic diagnosis and management of dysphagia: FEES and FEEST Conference 1996, Columbia Presbyterian Medical Center, New York.

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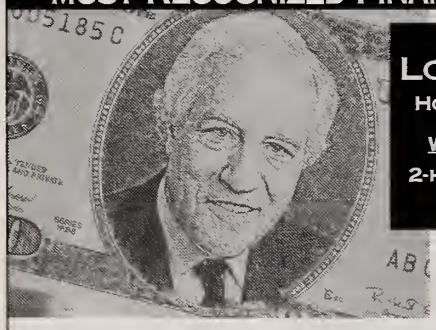
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Potentially Productive Years of Life Lost (PPYLL) in Kentucky Due to Occupational Fatalities, 1994-1996

Tim W. Struttmann, MSPH; Amy Scheerer, MSPH; Ellyn Moon, MA

A population-based occupational fatality surveillance system was used to identify 452 work-related fatalities in Kentucky over a 3-year period. Three hundred eighty-six workers less than 65 years old were included in this analysis of potentially productive years of life lost (PPYLL). A total of 9,275 years of potentially productive life were lost due to these occupational fatalities, costing the state economy $148 million in lost wages. Most of this loss (70%) was in the industries of transportation/communication/public utilities, manufacturing, mining and construction. The transportation/communication/public utilities division alone accounted for 21.4% of the total lost earnings. The agriculture/forestry/fishing division exceeded all others in potentially productive years of life lost. However, because of its lower mean income and older ages at death, that division ranked fifth in lost earnings. This article demonstrates that prevention resources should be directed at the agriculture, transportation, and logging industries, and to the prevention of fatalities caused by tractors, motor vehicle crashes, and falling objects, to be most effective in reducing the enormous economic burden of occupational fatalities.

During 1994-1996, 452 workers were killed while working in Kentucky. In 1996, Kentucky's occupational fatality rate was 8/100,000 (KY FACE unpublished data) — the national rate was 5/100,000.[1] *Healthy Kentuckians 2000* established as a goal the reduction of work-related deaths to no more than 4/100,000 full-time workers by the year 2000.[2] To achieve this goal will require the concerted efforts of business leaders, policy makers and public health professionals, as well as employers and workers. This article is offered as an evaluation of the impact of these occupational fatalities in terms of potentially productive years of life lost and wages lost, and as a summary of the economic burden of occupational fatalities to the state. It is hoped that this analysis will prove helpful in achieving the goal of *Healthy Kentuckians 2000.*

Evaluation of the enormous impact workplace fatalities have on the economy allows prevention resources to be allotted appropriately. One tool for evaluation is Years of Potential Life Lost (YPLL),[3,4] which is calculated by subtracting the age at death from an expected lifespan. The result is the number of life years lost as the result of premature death.

YPLL has been used to study preventable deaths due to disease and injury.[3,4] Because it uses the age at which death occurs, not simply the number of deaths,[4,5,6] YPLL can be used to rank the societal impact in terms of years lost due to different causes of death. Researchers have used YPLL to rank causes of premature death and to identify trends,[7] to examine motor vehicle crashes (MVCs) as a side effect of industrialization, and to compare health problems among countries.[8]

YPLL is weighted heavily by deaths occurring at early ages because it is calculated by subtracting a person's age at death from an expected endpoint and summing the results.[4,5,6] For example, based on an expected lifespan of 70 years, if a 51-year-old person is killed, the resulting YPLL is 19 (70 minus 51), whereas a 24-year-old's death would result in a YPLL of 46 (70 minus 24).

One extension of the YPLL which is well suited to the study of occupational fatalities is the Potentially Productive Years of Life Lost (PPYLL) method,[9,10] which allows estimation of economic costs by considering future income lost. PPYLL is calculated to measure the burden of premature death in a given population by using a projected retirement age as the endpoint. The objective is to sum the YPLL for all premature deaths in the population, industry or cause[6] and to calculate the future income sacrificed[11] by assigning a dollar value to each year of potentially productive life lost. Researchers in Alaska have used PPYLL to determine future earnings lost as a result of occupational fatalities for the purpose of targeting intervention efforts.[12]

Mr Struttmonn is offiliated with the Kentucky Injury Prevention ond Research Center, Southeast Center for Agriculturol Health ond Injury Prevention.

Source of support: Notionol Institute for Occupationol Safety ond Health (NIOSH) Cooperotive Agreement Number U60/CCU409879-04 to the Kentucky Deportment of Public Health.

This use of PPYLL is simple to compute and easy to comprehend when four assumptions are understood. First, PPYLL is a measure of lost future earnings based on age at death and average annual earnings by industry; it is not a reflection of a worker's or an industry's relative value to society. Second, the choice of an endpoint from which to calculate PPYLL dramatically affects the dollar value and the associated ranking. Third, PPYLL prioritizes industry, occupation, or cause of death based on the future earnings sacrificed. Fourth, the calculation of PPYLL assumes that every worker would retire at the same age.

For this study, we examined 3 years of Kentucky occupational fatality data and projected future earnings lost within each of 10 industry divisions. These projections will afford public health professionals a better understanding of the economic toll of occupational fatalities. Ranking industries, occupations, and external causes of fatal injury can assist policy makers and prevention specialists in making decisions about the allocation of scarce prevention resources.

Table 1. Average Age at Death and Average PPYLL by Industry Division, 1994-1996

Industry Division	Total Fatalities	Average Age at Death	Average PPYLL
Retail Trade	20	32.5	32.4
Public Admin.	30	34.9	30.1
Mining	36	37.6	27.3
Construction	47	37.9	27.1
Services	26	38.8	26.1
Manufacturing	57	40.9	24.0
Fin./Ins./Real Est.	5	42.0	23.0
TCPU	70	42.9	22.1
Wholesale Trade	8	43.1	21.8
Agri./Forest./Fish.	87	46.8	18.1
Total	386		

Table 2. Lost Future Productivity Due to Work-Related Fatal Injury by Industry Division, 1994-1996

Industry Division	Earnings Lost (in millions)	Average Cost	% of Total
TCPU	$ 31.8	$ 455,275	21.5
Manufacturing	$ 28.2	$ 494,977	19.0
Mining	$ 26.1	$ 725,202	17.5
Construction	$ 17.9	$ 381,108	12.0
Agri./Forest./Fish.	$ 13.5	$ 155,281	9.2
Public Admin.	$ 13.2	$ 440,763	8.8
Services	$ 8.0	$ 311,383	5.4
Retail Trade	$ 4.9	$ 247,513	3.3
Wholesale Trade	$ 3.3	$ 421,651	2.3
Fin./Ins./Real Est.	$ 1.6	$ 323,146	1.1
Totals	$148.8	$ 385,673	100.0

Methods

Data

Occupational fatality data for this study were obtained from the Kentucky Fatality Assessment and Control Evaluation (KY FACE) Project. KY FACE is one of 16 state FACE Projects funded by the National Institute for Occupational Safety and Health (NIOSH). The concept of occupational fatality and the criteria for inclusion in the data set were defined in a prior article.[1] Briefly, an occupational fatality was defined as a traumatic fatality that occurs while an individual is working for pay or in specified volunteer positions, either on or off employer premises. The *Standard Industrial Classification Manual*[13] was used to code for industry. The *Alphabetical Index of Industries and Occupations*[14] was used to classify occupation. The *International Classification of Diseases (ICD-9)*[15] was used to code for external cause. Data analysis was performed using *EPI INFO*.[16]

Computation of PPYLL

PPYLL was calculated for each occupational fatality that occurred between January 1, 1994, and December 31, 1996, using the following formula:

[age 65] - [age at death] = PPYLL

Age 65 was chosen because it is widely considered to be the usual age for retirement from the work force.[4,5] Lost wages were calculated by using the average annual earnings for 10 major industry divisions in Kentucky for 1994.[17] Future wages sacrificed were discounted at 4%.[18]

Results

For the 3-year period 1994 through 1996, 386 workers under age 65 lost their lives while working in Kentucky. Among the 10 industry divisions, agriculture/forestry/fishing had the greatest number of deaths (87), with transportation/communication/public utilities (TCPU) (70) and manufacturing (57) ranking second and third, respectively. Interestingly, the agriculture/forestry/fishing division ranked last in average PPYLL (18.1) because of its high average age at death (46.8). The retail trade division accounted for the highest average PPYLL (32.4) because its average age at death was the youngest (32.5) (see Table 1).

Lost Productivity

Table 2 shows potential worker earnings lost due to premature death by industry division. By using the model described, these totaled $153 million during the 3-year period. Mining had the highest cost per death and accounted for 18% of the total

Table 3. PPYLL by Industry Division, 1994-1996

Industry Division	1994 PPYLL	1994 Ronk	1995 PPYLL	1995 Rank	1996 PPYLL	1996 Rank	Total PPYLL	Total Rank
Agri./Forest./Fish.	493	3	543	1	541	3	1577	1
TCPU	494	2	284	5	770	1	1548	2
Monufocturing	491	4	462	2	417	4	1370	3
Construction	548	1	416	3	309	6	1273	4
Mining	299	7	357	4	328	5	984	5
Public Admin.	195	8	160	7	548	2	903	6
Services	408	5	169	6	104	7	681	7
Retoil Trode	391	6	160	7	98	8	649	8
Wholesale Trade	33	10	86	8	56	9	175	9
Fins./Ins./Real Est.	59	9	25	9	31	10	115	10
Totols	3,411		2,662		3,202		9,275	

Table 4. PPYLL by Occupation, 1994-1996

Occupation Category	1994 PPYLL	1994 Rank	1995 PPYLL	1995 Ronk	1996 PPYLL	1996 Ronk	Total PPYLL	Total Ronk
Oper./Fobricotor/Lobor.	1099	1	1162	1	1046	1	3307	1
Forming/For./Fishing	772	2	677	2	618	2	2067	2
Prec. Prod./Croft/Repoir	665	3	371	3	612	3	1648	3
Tech./Sales/Admin. Sup.	276	5	176	4	242	5	694	4
Monog./Prof.Spec.	301	4	120	6	180	6	601	5
Military	89	7	23	7	419	4	531	6
Service	209	6	133	5	85	7	427	7
Totols	3,411		2,662		3,202		9,275	

Table 5. PPYLL by Externol Cause of Fatal Injury (E-Code), 1994-1996

Externol Couse of Fotol Injury	1994 PPYLL	1994 Ronk	1995 PPYLL	1995 Ronk	1996 PPYLL	1996 Rank	Total PPYLL	Total Rank
MVC	1020	1	814	1	673	1	2507	1
Mochinery	492	3	650	2	560	2	1702	2
Folling object	566	2	254	4	511	3	1331	3
Homicide	373	4	96	7	260	5	729	4
Foll	147	8	202	5	211	6	560	5
Electrocution	165	7	256	3	138	8	559	6
Air Tronsport	32	13	13	13	376	4	421	7
Other	218	5	193	6	9	14	420	8
Explosion	179	6	52	8	94	11	325	9
Drowning	72	9	30	11	152	7	254	10
Fire	37	12	46	9	77	10	160	11
Noture/Env.	43	11	42	10	21	13	106	12
Suffocotion	63	10	0	—	38	12	101	13
Flying obj./Caught in	4	14	14	12	82	9	100	14
Totals	3,411		2,662		3,202		9,275	

lost earnings. TCPU had the greatest loss of potential earnings.

PPYLL by Industry

During 1994-1996, a total of 9,275 years of potentially productive life were lost due to occupational fatalities. Table 3 ranks the PPYLL by industry division for each of the 3 years. For the entire period, the agriculture/forestry/fishing industry division ranked highest in PPYLL. An average of 526 years of potentially productive life were lost each year in that division.

PPYLL by Occupation

Annual ranking of PPYLL by occupational category showed that operators/fabricators/laborers had consistently the highest total PPYLL (Table 4). Those in operator/fabricator/laborer and farming/forestry/fishing occupations constituted over half (58%) of the total PPYLL for the 3-year period.

PPYLL by External Cause of Fatal Injury

PPYLLs were ranked by cause in Table 5. During 1994-1996, worker deaths resulting in consistently high PPYLLs were caused by MVCs, machinery,

and falling objects, which together accounted for 60% of the total PPYLL.

Discussion

This analysis of occupational fatalities bears some similarities to the study of Alaska fatalities by Klatt et al.[12] However, we have ranked the 10 conventional industry divisions as well as examining PPYLL in terms of occupational categories, causes of death, and lost earnings within each division. Our intent was to provide a comprehensive ranking using PPYLL to elucidate occupational fatalities as a major public health problem and to offer policy makers a rationale for allocating prevention resources.

Industry

The agriculture/forestry/fishing division exceeded all others in PPYLL. The vast majority of these fatalities (78%) were in agriculture. The leading cause (45%) of these farming fatalities was tractors. TCPU industries ranked a close second in PPYLL. Fifty-eight percent of the fatalities in TCPU industries were the result of MVCs involving commercial drivers. Ranking third in PPYLL, the manufacturing division accounted for nearly 15% of the total PPYLL. Logging incidents constituted 52% of the manufacturing fatalities. The construction industry ranked fourth in PPYLL. Together, these four divisions accounted for 62% of the total PPYLL, costing over $30 million per year in lost earnings. In Kentucky, just 31% of the workforce is employed in these four industry divisions.[19]

Although agriculture/forestry/fishing ranked first among industrial divisions in PPYLL, the agricultural industry accounted for a relatively low proportion of lost earnings due to its low mean income and high ages at death. Moreover, because our study population only included persons under age 65 and many farmers continue working well past that age, agriculture was further underrepresented in this study.

The mining division's cost per death is unusually high due to the high average annual earnings and the low average ages at death compared to other industry divisions.

Occupation

Operators/fabricators/laborers exceeded all other occupational categories for the 3-year period, accounting for 36% of the PPYLL. Deaths of commercial drivers made up 43% of those fatalities. The farming/forestry/fishing occupation category ranked second in PPYLL. Farm fatalities accounted for 67% of these. Third was the precision production/craft/repair category, which includes construction and mining occupations. Those working in technical/sales/administration and managerial/professional specialty occupations ranked fourth and fifth, respectively. Fatalities in those two categories were primarily due to MVCs, and their PPYLL rankings were high because the deaths tended to occur at younger ages.

Cause

MVCs resulted in the highest PPYLL every year during the study period. Work-related crashes made up 3.5% of the statewide YPLL for MVCs.[20] These MVCs cost the state economy $13.4 million per year in future earnings lost. Machinery ranked second for the 3-year period. Farm tractors were involved in 83% of the fatal machinery incidents, costing the state economy $2.8 million per year in lost future wages. The falling object category had the third highest PPYLL. Forty percent of these incidents were attributable to logging activities (eg, falling trees and branches, logs rolling off trucks). Homicide ranked fourth in PPYLL primarily because of the low average age of victims; it cost the state economy nearly $3 million per year in lost future wages. Twenty-nine percent of the homicide cases were robberies. Work-related homicides made up 3% of the state's homicide YPLL.[20] Air transport, ranked seventh, was the result of two military helicopter crashes that claimed 11 young lives in 1996.

Limitations

PPYLL was originally intended to compare the relative cost of various causes of death in the general population.[4,5] We used PPYLL to assess the economic impact of traumatic fatalities among workers.

To calculate a lost income per fatality, we used a mean income for each industry in Kentucky. In some cases this could have been an over- or underestimate of the actual income lost due to the premature death. This study assumed a constant stream of income and therefore did not account for wage increases that a worker typically experiences during the course of employment, nor did it incorporate adjustments for inflation. This method of calculation also did not account for exits in the labor market that were not attributable to death or retirement, such as disability, poor health, or structural unemployment. In addition, calculations did not take into consideration the month an individual was killed. For example, the PPYLL for a person who died in December 1994 would be the same as for one who died in January 1994.

We only calculated the individual's lost income, not pain and suffering, legal/administrative costs, medical services, or workplace costs. To base the value of a lost life solely on lost wages constitutes a gross underestimate of the total burden of a premature death.

Calculations made here do not account for the segment of the workforce age 65 and over. However, this group contributes to the economic vitality of a community. Over the 3 years studied, 59 workers over 64 years of age were killed. Of these, 43 (73%) were in agricultural occupations. Therefore these rankings underestimate the economic burden of agricultural fatalities.

Conclusion

This study's value lies in the fact that it presents, in simplified form, a description of the relative magnitude of the occupational fatality problem by using PPYLL as a tool for evaluating the economic impact to society. Public health professionals and policy makers can use this information to allocate prevention resources. Based on our analysis by industry division and occupation category, prevention resources should be directed at occupational fatalities in the agriculture, transportation, and logging industries. This finding is underscored by our analysis of causes, which indicates that prevention resources should be directed at injuries related to machinery (ie, tractors), MVCs, and falling objects (ie, trees/limbs/logs).

Future studies should include a more detailed examination of lost earnings by occupation (rather than industry), cause, and geographic distribution. This would allow further insights into the most costly occupations, mechanisms, and locations based on earnings sacrificed. Furthermore, an analysis of industries based on the *North American Industry Classification System (NAICS)*[21] should be conducted when it becomes available, as industry groupings will change, thereby possibly altering conclusions. For example, under the new system the logging industry, currently grouped with manufacturing, will be included with agricultural and forestry industries.

References

1. Struttmann TW, Moon-Hampton E, Scheerer A, Pollack SH, Spurlock C. Occupational fatalities in Kentucky — 1994. *J Ky Med Assoc.* 1996; 94:395-400.
2. Coffey D ed. *Health Kentuckians 2000: Kentucky's Public Health Objectives for the Year 2000.* Frankfort KY: Cabinet for Human Resources, Department of Health Services; 1991.
3. Foege WH, Amler RW, White CC. Closing the gap: Report of the Carter Center health policy consultation. *JAMA.* 1985;254: 1355-1358.
4. Centers for Disease Control and Prevention. Premature mortality in the United States: Public health issues in the use of years of potential life lost. *MMWR.* 1986;35(2S):ls-11s.
5. Centers for Disease Control and Prevention. Introduction to Table V, premature deaths, monthly mortality, and monthly physician contacts — United States. *MMWR.* 1982;31:109-110.
6. Gardner JW, Sanborn JS. Years of potential life lost (YPLL) — what does it measure? *Epidemiology.* 1990;1:322-329.
7. Arca M, DiOrio F, Forastiere F, Tasco C, Perucci CA. Years of potential life lost (YPLL) before age 65 in Italy. *Am J Public Health.* 1988;78:1202-1205.
8. MacKinney T, Baker T. Impact of motor vehicle injury in Taiwan using potential productive years of life lost. *Asia Pac J Public Health.* 1994;7:10-15.
9. Perloff JD, LeBailly SA, Kletke PR, Budetti PP, Connelly JP. Premature death in the United States: Years of life lost and health priorities. *J Public Health Policy.* 1984;6:167-184.
10. Centers for Disease Control and Prevention. Firearm-related years of potential life lost before age 65 years — United States, 1980–1991. *MMWR* 1994;43(33):609-612.
11. Stickle G. What priority, human life? *Am J Public Health.* 1965;55:1692-1698.
12. Klatt ML, Kennedy RD, Conway GA. Years of potential life lost and lost future productivity due to occupational fatalities — Alaska, 1990-1994. *Alaska Medicine.* 1995;37:123-125.
13. Office of Management and Budget. *Standard Industrial Classification Manual — 1987.* Springfield VA: National Technical Information Service.
14. US Department of Commerce, Economics and Statistics Administration, Bureau of the Census. *Alphabetical Index of Industries and Occupations.* Washington DC: US Government Printing Office, 1992.
15. Karaffa MC, ed. *International Classification of Diseases, 9th Revision, Clinical Modification, 4th ed. 1993.* Los Angeles CA: Practice Management Information Corporation, 1993.
16. Dean AG, Dean JA, Coulombier D, et al. *EPI INFO, Version 6: A Word Processing, Database and Statistics System for Epidemiology on Microcomputers.* Atlanta GA: Centers for Disease Control and Prevention. 1994.
17. US Department of Commerce, Bureau of Economic Analysis. 1996. *The Regional Economic Information System. (CD-ROM).*
18. Lipscomb J, Weinstein MC, Torrance GW. 1996. Time Preference. In: *Cost Effectiveness in Health and Medicine,* Gold MR, Seigel JE, Russell LB, Weinstein MC, eds. New York: Oxford University Press.
19. US Department of Labor, Bureau of Labor Statistics. *Geographic Profile of Employment and Unemployment, 1993.* Washington DC: US Government Printing Office (Bulletin 2446). September 1994.
20. Kentucky State Center for Health Statistics. *Kentucky County Health Profiles, 1995.* Frankfort KY: Cabinet for Health Services, 1997.
21. US Census Bureau. *North American Industry Classification System (NAICS).* Internet. 1997.



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Just a Dot on the Line

"Time puts marks on us, like rings in the tree, and some of the lines are thicker than others. Life impacts us in different ways. That we can care for such a diversity of people is our gift."

With some fatigue, curiosity and compulsion, I return phone calls at the end of the day. These conversations are not punctuated by emergency, but more often search your mind for answers to some difficult questions. My 78-aged patient had sent me a letter salvo, questioning the results of her visit, the necessity for treatment, and the prognosis. Certainly not complimentary, the handwritten note bore the heavy penning of someone angry and afraid. Not willing to let the letter be filed, or worse discarded, I studied its contents in the quiet of the evening office milieu, deciding how to confront or to console, to educate or to lecture this patient. My professors and teachers seemed immune, even buffered, from such interaction by residents and students on the frontline. Experience taught me that they also had these moments, that the patience and care many of them had for their patients was genuine, not just for show. Sometimes words, other times a slight touch or embrace dissolved the crisis and perpetuated the long relationship of patient to doctor that was in jeopardy. Sitting in judgement of colleagues about their professional behavior, their malpractice insults, and their interaction with insurance companies educated me. Now it was my turn again, this time on the phone rather than in the examining room, like the ombudsman ferreting out truth from libel, misrepresentation from deception.

After many rings and my temptation to postpone the call, she answered with a faint, but definitive voice. My picture of her was accurate, and her thin frail body on the table mirrored the wear and tear of years toiling in physical labor. Illness and aging had chipped away at her exterior, precipitating her appointment with me for the ulcerating lesion on her lip. Having used her voice working, and expressing herself vividly with many facial contortions, her lip malady was not only an insult, but a detriment to her interacting. My office examination extended to inspecting the rest of her skin, but not without her protest that nothing else was amiss. Like the body builder with a diminished body, she took pride that what was left of her skin and bones were in good shape, if not shaped well.

Her retort to my introduction of my name was to remind me that I could not have remembered her from the other patients, that she was my final appointed patient, and that my tired look betrayed my desire to be done with her. In fact she had an impact at the time, because her wily way and personality challenged anyone to care for her. Part of her indictment accurately describes any of us at the end of the day, but I continue to be grateful in today's medicine for the opportunity to see my patients unchallenged by some insurance predicament. Her referral from another physician was to be my only compliment.

She resurrected the contents of her letter, stabbing each point on the dartboard masquerading as my ear. Punctuated by some decibel changes, she reiterated that she did not need to have her lesion removed. After explaining that she had an aggressive skin cancer that already destroyed part of her lip, she countered mistakenly that I had previously told her she had

no cancer. She recalled my phoning her the results the evening after her biopsy, but emphatically stated that I told her she had no problem. Again some truth was there, in my having told her at the time that her lesion bore little ominous consequences, that although the local damage was permanent, she had a safe prognosis. This hurdle jumped, the next in her steeplechase diatribe was that my hurrying her through the visit caused her pain. Despite the fact that she had to have anesthesia, which does hurt momentarily, and the fact that I preceded the procedure by doing a complete skin examination, she concluded that I had no time for her. The truth here is that sometimes we all hurt people and sometimes we do more than the patient bargained for in making the visit. My compulsion to reduce her ultimate discomfort and to assure her and myself that I was not dismissing the rest of her body for the sake of a lip lesion left her not grateful, but critical. My contract accepted the charge to care for what she wanted, but my duty and my ethics pushed me further. This explained, but only partially agreed, I started my parting statement with a wish for her good health.

She and I were immigrants' children. With a loving family and minimal economic resources, we worked most of our youth, and played occasionally. She went on to describe that working all her life demanded that she care for her body and mind, so that she could continue to provide. My wishing her well was fine, but she could take care of herself, just like she had done the 78 years that preceded her visit to my office. Physicians usually were unnecessary, even her more trusted personal one. Our one visit in her life experience was a dot on the line, not even an exclamation point. Nevertheless, I pushed my salutation because we need more people like this woman, with or without her character. She ended by thanking me for my time and I with a suggestion that whomever she saw in the future should watch that her lip did not suffer a recurrence.

My read on all this is that there is something to be learned from each patient. My 20 minutes with her needed precise information about her lip. Any other agenda was mine, whether she recognized that she benefited. Time puts marks on us, like rings in the tree, and some of the lines are thicker than others. Life impacts us in different ways. That we can care for such a diversity of people is our gift.

Stephen Z. Smith, MD

The Loaves and the Fish



Jan Crase

"We have a $300 grant available from Southern Medical Association for a breast cancer awareness project. What kind of statewide project can we do for $300?"

That question was posed to me in an early morning phone call by Gwen Parson, Kentucky Health Projects Councilor for Southern Medical Auxiliary. My first thought was that the miracle of the loaves and the fish was needed to stretch $300 into having any significant impact — especially statewide. Being at a loss for ideas, I simply said, "Let me think about it."

The following week, Gloria Sams with the Kentucky Cancer Program was called regarding the latest developments with breast cancer awareness. Her response, that teachers have a 60% higher mortality rate of breast cancer than any other profession, was quite startling. She also shared details about a project she had completed the previous spring in two school systems, including the Somerset school system, where she convinced the superintendent to put a flyer explaining the importance of mammograms in the last paycheck of each teacher. The response of teachers had been very positive and apparently several had gotten breast exams and mammograms.

This had the potential to be a wonderful project, but to take it statewide would encounter numerous challenges. First of all, there are 176 school districts in Kentucky and each district issues its own payroll checks; therefore, each of the 176 superintendents would need to be contacted and convinced to participate. The Department of Education would need to give approval of the project. The Department for Public Health would need to participate. Then of course there was the challenge of distribution of the materials themselves. It very quickly became obvious that this project would only be possible by forming lots of coalitions.

To make a long story short, 37 phone calls were made and one trip was made to Frankfort to discuss the best ways of implementation, funding, potential problems, etc. **The Department of Public Health** helped with the funding; Dr Cody with the **Department for Education** wrote a letter to each superintendent requesting their participation; the **Kentucky Cancer Program** in Somerset took on the responsibility of coordinating distribution; the **Alliance** County Presidents were asked to contact their superintendents requesting their participation; and the **KMA** was approached for their approval and participation. **The Kentucky Breast Cancer** Coalition signed on also.

One hundred thousand flyers, explaining the importance of mammograms, were printed and delivered to all the superintendents for distribution in the last paycheck of the school year for each teacher and each staff employee in the Kentucky Public School System. Alliance members in some counties printed additional copies and distributed them in the private schools as well. When the project all came together, there was enough funding to cover expenses and the **$300 was still left over!**

That $300 had to be spent or returned, so why not let charity begin at home and try to reach all of the Alliance members with breast cancer awareness information. Linda Piker with the Department for Public Health suggested using stickers on flower seed packets that said, "Mammograms can detect breast cancer when it is only the size of a tiny seed," and enough of these were purchased for every Alliance member in the state. These were given to the Alliance County Presidents to be distributed to the entire membership of their counties.

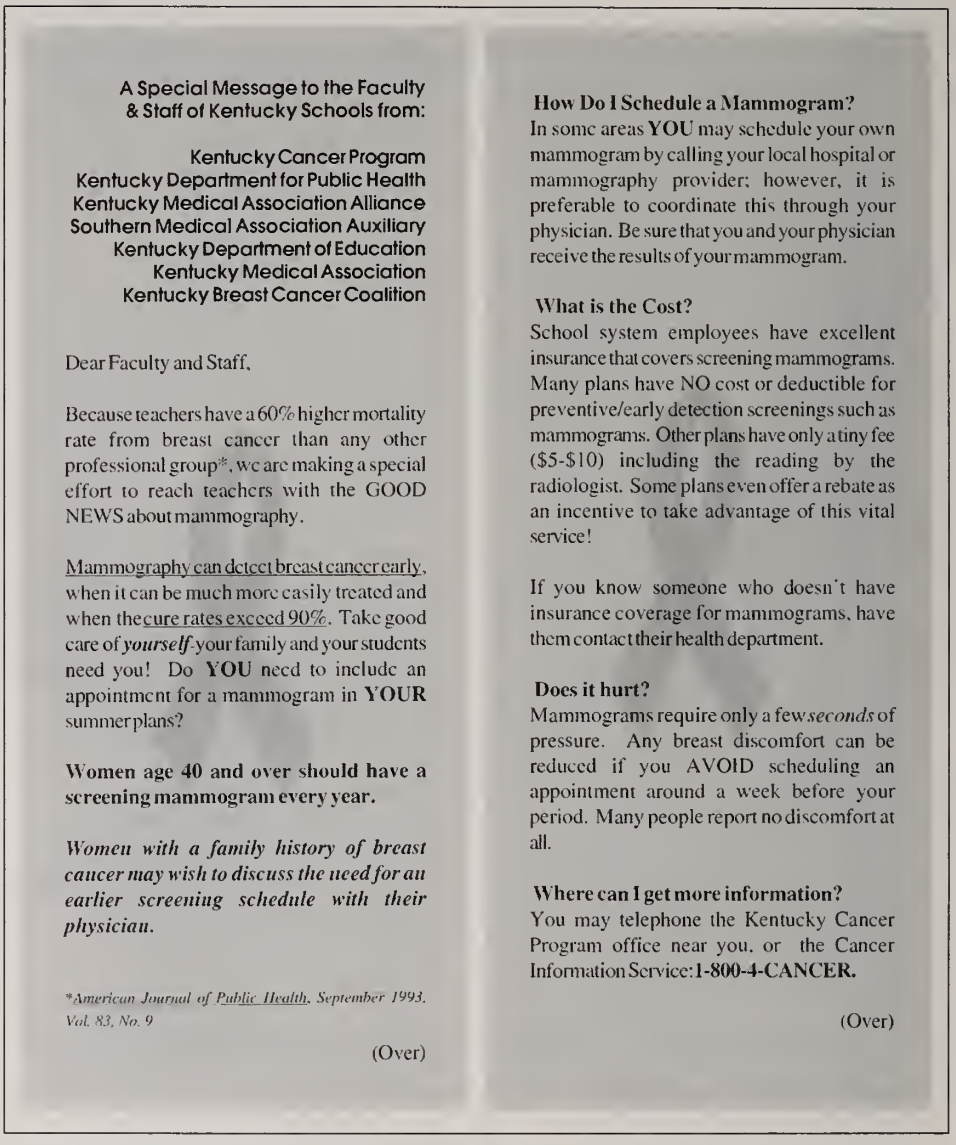
When vendors learned about the use of the seed and stickers, nice discounts were given and the total expense for both this seed project and the flyer project was only $195.71 leaving **$104.29 still to be spent!**

Some type of credible evaluation is needed for a project of this magnitude so the $104.29 will be used as part of an incentive package to get people to respond to questionnaires which will be sent out this fall. A physician's spouse, Dr Victoria Moore who has a PhD in Measurement Statistics has agreed to help with evaluations and getting some feedback of results and impact.

The other day a teacher approached me who received the flyer last year and she said, "Let me shake your hand and thank the Alliance for doing this project." When she received the flyer she said her first thought was, "This must be important since it came with my paycheck." Her second thought was, "How nice of these people to be concerned about *me*, *my* health and *my* well-being." The third thought was to get a mammogram scheduled. She could not believe that her last mammogram was 7 years ago. She had breast cancer which was in its very early stages and she credits the flyer for saving her life by encouraging her to get a mammogram.

The SMAA $300 grant was the catalyst for initiating both these breast cancer awareness projects. By forming coalitions with others for funding and research, the project became a reality and hopefully some lives will be saved. There is no doubt that lots of people are willing to help with worthwhile endeavors. Caring people do respond when given sufficient information about the need, and given specifics as to how they can be most effective with their response. We served the multitudes and still had funds left over. Yes, the loaves and fish story is a good comparison. I wonder, however, if the disciples had as much trouble getting rid of the left over loaves and fish as we have had trying to spend this $300!

Jan Crase
KMAA President



A Special Message to the Faculty & Staff of Kentucky Schools from:

Kentucky Cancer Program
Kentucky Department for Public Health
Kentucky Medical Association Alliance
Southern Medical Association Auxiliary
Kentucky Department of Education
Kentucky Medical Association
Kentucky Breast Cancer Coalition

Dear Faculty and Staff,

Because teachers have a 60% higher mortality rate from breast cancer than any other professional group*, we are making a special effort to reach teachers with the GOOD NEWS about mammography.

Mammography can detect breast cancer early, when it can be much more easily treated and when the cure rates exceed 90%. Take good care of ***yourself*** - your family and your students need you! Do **YOU** need to include an appointment for a mammogram in **YOUR** summer plans?

Women age 40 and over should have a screening mammogram every year.

Women with a family history of breast cancer may wish to discuss the need for an earlier screening schedule with their physician.

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(Over)

How Do I Schedule a Mammogram?
In some areas **YOU** may schedule your own mammogram by calling your local hospital or mammography provider; however, it is preferable to coordinate this through your physician. Be sure that you and your physician receive the results of your mammogram.

What is the Cost?
School system employees have excellent insurance that covers screening mammograms. Many plans have NO cost or deductible for preventive/early detection screenings such as mammograms. Other plans have only a tiny fee ($5-$10) including the reading by the radiologist. Some plans even offer a rebate as an incentive to take advantage of this vital service!

If you know someone who doesn't have insurance coverage for mammograms, have them contact their health department.

Does it hurt?
Mammograms require only a few *seconds* of pressure. Any breast discomfort can be reduced if you AVOID scheduling an appointment around a week before your period. Many people report no discomfort at all.

Where can I get more information?
You may telephone the Kentucky Cancer Program office near you, or the Cancer Information Service: **1-800-4-CANCER.**

(Over)

The flyer that was distributed to Kentucky teachers.

U of L Bids Farewell to Health Affairs VP Dr Donald Kmetz



Following a storied 33 year career as a Univeristy of Louisville administrator, Donald R. Kmetz, MD, has retired.

In 1965, Dr Kmetz came to Louisville as chief of pathology and director of the Children's Hospital Laboratory. He was named chief of pediatric hematology/oncology in 1969, acting dean of the medical school in 1980, medical school dean in 1981, and vice president for health affairs in 1992.

Dr Kmetz oversaw more than $50 million worth of construction projects during his 18 years as dean. Included were the restoration of the old Louisville General Hospital administration wing which now includes the Abell Administration Center; the Kosair Charities Pediatric Center; the K Building renovation; and the Baxter Biomedical Research Building, currently under construction.

Under his leadership, the school also added 17 endowed chairs, with another eight anticipated by the end of 1998.

Dr Kmetz is pictured addressing the House of Delegates during a KMA Annual Meeting. The Kentucky Medical Association thanks Dean Kmetz for being a champion for medicine and wishes him a happy and productive retirement.

. . . and Welcomes Dr Joel Kaplan to Fill the Post



On July 1, the University of Louisville named Joel A. Kaplan, MD, as vice president for Health Affairs/dean of the School of Medicine. He also is serving as senior vice provost for academic affairs and as a professor of anesthesiology.

Dr Kaplan came to Louisville following service as senior vice president for Clinical Affairs at Mount Sinai Medical Center, and as professor of anesthesiology at the Mount Sinai School of Medicine in New York. He is a respected scientist in the field of cardiac anesthesiology and is a past president of the Society of Cardiovascular Anesthesiologists. Dr Kaplan is extensively involved in numerous professional organizations and is a diplomate of the American Board of Medical Mangement and a Certified Physician Executive. He is a fellow of the American College of Anesthesiology, the American College of Chest Physicians, and the American College of Cardiology. The author of 9 textbooks, 24 text chapters, and 118 journal publications, he is also editor-in-chief of the *Journal of Cardiothoracic and Vascular Anesthesia* and that journal's "Updates."

Dr Kaplan graduated in 1968 from Jefferson Medical College, where he also served a one-year internship. Following his residency at the University of Pennsylvania Medical School's department of anesthesia, he spent an additional year there as a research fellow in cardiovascular physiology and pharmacology, and cardiac anesthesia. He subsequently spent 2 years as a clinical instructor at University of Texas Medical School in San Antonio, and 9 years at Emory University School of Medicine, progressing to an appointment as professor in 1979. He moved to Mount Sinai in 1983.

KMA welcomes Dr Kaplan as a member and looks forward to the continuum of the excellent relationship shared with the University of Louisville School of Medicine.

PEOPLE

Three KMA members received awards at the June AMA Annual Meeting for their work in recruiting members to the AMA. **Robert R. Goodin, MD,** a Delegate to the AMA and a member of the AMA Council on Medical Education, was recognized by the AMA House for recruiting more than 10 members this year. The Organized Medical Staff Section honored **John O'Brien, MD,** Louisville, for his continued efforts in recruitment, and **Judy Linger, MD,** received an award at the Young Physician Section meeting for recruiting 10 plus members.

KMA Executive Vice President **William T. Applegate** recently celebrated his 30th anniversary with the Kentucky Medical Association. He joined the Association in 1968 and served as Deputy Executive Vice President from 1972 until January 1997, when he was elevated to CEO by the KMA Board of Trustees.

Gilbert H. Friedell, MD, director for cancer control at the University of Kentucky Markey Cancer Center, has been selected to receive the 1998 Individual Community Service Award from the Susan G. Komen Breast Cancer Foundation. In addition to community service, these national awards are given for research, philanthropy, media, and volunteerism.



Dr Friedell developed and co-directs the state-funded Kentucky Cancer Program, which is jointly overseen by the Markey Cancer Center and the University of Louisville's Brown Cancer Center. It includes the nationally praised Kentucky Cancer Registry; the Community Outreach Division, which has nine regional offices across the state; and the National Cancer Institute's Region 9 Cancer Information Service, which covers Kentucky, Tennessee, and Arkansas.

Dr Friedell's career has been marked by an extraordinary dedication to public service. He supported and helped draft legislation that provides significantly increased access to breast cancer screening to women in Kentucky. His leadership and vision led to the creation of community cancer control programs, such as the Mountain SC-Outs program, which trained residents of remote communities to educate their peers about cancer.

Outside Kentucky, Dr Friedell has been instrumental in helping to start other state cancer registries, based on his work with the successful Kentucky registry. He also is executive director of the Governor's Task Force on Breast Cancer and chair of the Steering Committee of the National Cancer Institute-supported Appalachia Leadership Initiative on Cancer.

Eugene H. Conner, MD, KMA's historian, recently was installed as president at the 28th annual meeting of the American Osler Society (AOS) in Toronto, Ontario, Canada.

The AOS is a medical/historical society founded in 1970 by 17 physicians and allied professionals for the purpose of gathering together to share their common inspiration. It also memorializes and perpetuates the just and charitable life as well as the resourcefulness and ethical example of the intellectual **William Osler, MD** [1849-1919].

Peter W. Ross, Jr, MD, was the recipient of the Preservation Award given by the Louisville Historical League this year. Dr Ross purchased and renovated The St. Paul's Evangelical Church of Christ in Louisville. Most of the church has been kept in its original condition, but it has been remodeled slightly and functions as office space for Dr Ross and his partner **Luis Valesco, MD.**

Russell L. Travis, MD, FACS, of Lexington has been elected President of The American Association of Neurological Surgeons (AANS). The AANS is one of the largest neurosurgical societies in the world with over 5300 members from over 30 countries.

Active in the AANS since 1974, Dr Travis served as Director-at-Large of the AANS Board of Directors since 1993, and has also held such positions as Chairman of the Physician Reimbursement Committee and the Humanitarian Award Committee. For more than a decade, he played a key role in the leadership of the AANS/Congress of Neurological Surgeons (CNS) Washington Committee of Neurosurgery, speaking frequently before Congressional Committees in support of organized neurosurgery. He also served as Chairman of the Joint Section on Disorders of the Spine and Peripheral Nerves of the AANS and CNS, and of the Joint Council of State Neurosurgical Societies.

UPDATES

Rite Aid Pharmacies to Dispense Medications Through Health Kentucky, Inc

Rite Aid Corporation announced in July that its 139 Kentucky pharmacies will dispense medications at no charge to uninsured Kentuckians living below the Federal Poverty Level, and ineligible for Medicare or Medicaid, through the Kentucky Pharmacy Providers Program (KPP).

The pharmaceutical replenishment program is part of a unique voluntary effort through Health Kentucky, Inc and the Kentucky Pharmacists Association to provide

low-income Kentuckians access to quality health care. Participating physicians can write prescriptions for eligible patients off the list of available medications provided by Abbott Laboratories, Johnson & Johnson, Novo Nordisk Pharmaceuticals, Pfizer, and Parke-Davis. The pharmaceutical manufacturers then replenish product back to the pharmacy.

KMA Past President **Donald C. Barton, MD,** Corbin, recently completed his term as Health Kentucky President. Elected as President was Gretchen Brown, MSW, President and CEO of Hospice of the Bluegrass. **Salem M. George, MD,** Lebanon, a former KMA Trustee, was elected as Treasurer.

1998 OIG Projects

As reported in the July 1998 issue of *The Journal,* the Department of Health and Human Services, which oversees the Medicare program, drafts a "work plan" for its Office of Inspector General (OIG). The following are additional excerpts from the work plan that discuss the OIG's emphasis for 1998 on physician services within the Medicare system. The entire report can be obtained from the DHHS website at *http://www.dhhs.gov/progorg/oig.*

- **Physician and Other Service Provider Use of Diagnosis Codes**
  This review will examine a sample of services paid by Medicare. By comparing Medicare claims to beneficiary medical records, a medical reviewer will determine the extent of which diagnosis codes on claims match the reason for ordering and providing various services. In a previous report entitled "Imaging Services for Nursing Facility Patients: Medical Necessity and Quality of Care" it was found that physicians and other providers of imaging services do not follow HCFA's guidance on use of diagnosis codes.
- **Physician Credit Balances**
  This review will determine whether physicians are reviewing their records for Medicare credit balances and refunding to their carriers those indicating an overpayment. A credit balance occurs when a provider receives and records higher reimbursement than the amount actually charged to a specific Medicare beneficiary. Some credit balances result from duplicate payments and in these cases a Medicare overpayment exists. Past OIG work which identified credit balances at hospitals resulted in significant recoveries for the Medicare program.
- **Multiple Discharges**
  We will determine whether duplicate payments have been made for day of discharge patient management services. Discharge day management can only be billed by the admitting physician. In one state, examples were noted where two or more physicians are billing for discharge day management for the same beneficiary admission. A computer application will be developed to identify those beneficiaries whose discharge day management was billed by more than one physician during a single inpatient stay.
- **Anesthesia Services**
  This review will identify anesthesiologists who bill for personally performed services and determine if these services were in compliance with Medicare regulations. Several instances were found where anesthesiologists were improperly billing for supervising residents in three or more operating rooms at the same time.
- **Billing for Services Rendered By Physician Assistants**
  OIG will determine whether physicians are improperly billing for services rendered by physician assistants. Medicare allows physician assistants to render certain services as "incident to" services, which are billed by the employing physician as if the service was personally rendered by the physician. However, if the services do not fall under the "incident to" criteria, the employing physician must bill using a modifier which reduces the Medicare payment. Medicare is overpaying physicians who improperly bill physician assistant services as "incident to" rather than using the proper modifiers.

Downcoding Problems Reported

The Texas Medical Association has reported that one of its largest managed care companies has automatically downcoded a mid- to high-level E & M code to a lower level without requesting documentation to substantiate the level of service. Physicians' staffs should carefully look at referral authorizations to make sure the level of service hasn't been predetermined and appeal downcoding where documentation justifies the higher code.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

David G Sanford MD — OPH
2329 Cumberland Ave, Middlesboro 40965
1993, U of Kentucky

Breckinridge

Ashok Kapur MD — IM
2 Monarch Lane Apt 1, Hardinsburg 40143
1979, Christian Med Col, India

Campbell

Nicholas T Gates MD — ORS
210 Thomas More Pkwy, Crestview Hills 41017-3498
1992, Ohio State, Columbus

Carroll

Bernd Raphael MD — IM
1106 Gillock Rd Apt B4, Carrollton 41008-9507
1986, Heidelberg U, Germany

Clay

Millard Lynn Fogleman MD — FP
H C 69 Box 701, Beverly 40913
1980, U of Kansas

Clark

Oliver C James II MD — AN
213 Al Fan Ct, Winchester 40391
1991, U of Louisville

Daviess

Robert S Walsh MD — TS
815 E Parrish Ave Ste 440, Owensboro 42303
1982, Albany Med Col

Fayette

Lowell D Kennedy MD — AN
PO Box 21730, Lexington 40522-1730
1982, U of Kentucky

Kristine J Krueger MD — GE
3624 Burning Tree Lane, Lexington 40509-1932
1985, U of Florida

Christopher J Kwolek MD — S
2349 Abbeywood Rd, Lexington 40515-1259
1987, U of California, San Francisco

Howard Markowitz MD — ORS
120 N Eagle Creek Dr Ste 440, Lexington 40509
1985, Temple U

Kenneth R Noel MD — AN
Dept Of AN N 203 Med Center Bldg 0084, Lexington 40536-0084
1967, Loma Linda U

Adrian E Park MD — S
218 Wind Haven Dr, Nicholasville 40356-8009
1987, U of McMaster, Canada

Nicci M Pittman MD — FP
4864 Bud Ln, Lexington 40514-1416
1994, U of Kentucky

Christopher D Prevel MD — PS
551 Ginermill Ln, Lexington 40509
1983, Emory U, Georgia

Randall G Rowland MD — U
UKMC MS-283 0084, Lexington 40536-0084
1972, Northwestern U, Chicago

Franklin

Sandra L A Swayze MD — R
2 Physicians Park Drive, Frankfort 40601
1991, Louisiana State U, Shreveport

Hopkins

Bhaskaran N Sreekumar MD — C
444 S Main St, Madisonville 42431
1986, Madras U, India

Hardin

Ronald Crafton MD — EM
2505 Chatsworth Dr, Elizabethtown 42701-8674
1992, U of Louisville

Jefferson

William L Betsill Jr MD — PTH
1407 Cold Springs Rd, Louisville 40217
1973, Med U of S Carolina

Ramona M Browning MD — PD
6801 Dixie Hwy Ste D102, Louisville 40258
1991, U of Texas, San Antonio

Sergio A Cardinali MD — IM
12810 Dove Lake Dr, Louisville 40299-8339
1994, U of Louisville

Thomas Edward Downs MD — IM
5804 Bonfire Dr, Louisville 40207
1994, U of Texas, Galveston

Ronald J Elin MD — P
7015 Windham Pky, Prospect 40059
1969, U of Minnesota, Minneapolis

Thomas Matthew Fuhrman MD— AN
Dept of Anesthesia, Louisville 40292
1983, U of Texas, Houston

Cynthia C Gawarecki MD — P
PO Box 16848, Louisville 40256-0848
1993, U of Louisville

Stephen J Kavka MD — PS
6611 Foxcroft Rd, Prospect 40059
1965, U of Chicago

Annette Jacqueline Nader MD —
4001 Dutchmans Ln Ste 4 B, Louisville 40207-4736
1987, Northeastern Ohio U

Jonathan F Noel MD — S
911 N Salem St, Salem 47167
1992, U of Louisville

Michael Ostapchuk Jr MD — FP
1433 Saint James Ct Apt 4, Louisville 40208-2137
1987, U of Kentucky

Michael Phelps MD — IM
8604 Glenfield Way, Louisville 40241
1993, U of Louisville

John D Powers MD — PTH
10900 Old Harrods Woods Cir, Louisville 40223
1985, U of Louisville

Saghar Shafizadeh MD — PD
2201 Greentree N, Clarksville 47129
1993, U of Louisville

James F Shields PhD —
5408 Navajo Rd, Louisville 40207-1685
1993, Spalding U

Wayne K Stadelmann MD — PS
2120 Cherokee Pkwy, Louisville 40204
1990, U of Chicago

Natalie Graham Stephens MD — S
3635 Warner Ave, Louisville 40207-3729
1991, U of Louisville

Merritt Ashley Tolan MD — AN
9407 Holiday Dr, Louisville 40272
1992, Med U of S Carolina

Regi Varghese MD — IM
2924 Winterhaven Rd, Louisville 40220
1991, Bangalore Med Col, India

Johnson

Francis E Bruno MD — OBG
10 E Dorton Blvd, Staffordsville 41256
1970, Tufts U

Kenton

LaRoy F Kendall MD — EM
1 Medical Village Dr Emergency Dept, Edgewood 41017
1990, U of Kentucky

Mark S Meier MD — IM
401 E 20th St Ste 101, Covington 41014-1585
1982, U of Louisville

Knox

Vinayak P Bhavalkar MD — ORS
226 Sycamore Dr, Barbourville 40906-1130
1963, G S MED Col, India

Laurel

Daniel A Chung Tze Chong MD — FP
195 Morgan Street Ste 3, London 40741
1985, Uludaq Med Fac, Turkey
Thomas E Mechas MD — OBG
125 Mink Lane, London 40744
1986, U of Montreal

McCracken

Polly Johnson MD — IM
225 Medical Center Dr Ste 201, Paducah 42002-7448
1994, U of Louisville
David Olson Montgomery MD — S
225 Medical Center Dr, Paducah 42002-7329
1993, U of Louisville
Timothy E Shiben MD — GE
225 Medical Center Dr Ste 307, Paducah 42003-7914
1991, W Virginia U

Morgan

Mauro C Janoski MD — IM
622 Broadway St Apt A, West Liberty 41472
1983, Universidade Federal do Para, Brazil

Perry

Noel D Tan MD — PD
103 Adams Rdg, Hazard 41701-9445
1983, U of Santo Tomas, Philippines

Pike

Rosanne R Nichols MD — PD
145 Weddington Branch Rd, Pikeville 41502
1994, Quillen-Dishner Col, Tennessee

Rockcastle

Michael D Hamilton MD — FP
P O Box 1525, Mt Vernon 40456
1995, U of Kentucky

Warren

Sam Reddy Kesri MD — IM
350 Park St Ste 203, Bowling Green 42101
1988, Osmania Med Col, India
Ramesh P Talreja MD — AN
383 Deer Meadow Ave, Bowling Green 42103-7041
1980, Grant Med Col, India

IN-TRAINING

Fayette

Sundhar R Ramasamy MD — OPH
Haoran Yu MD — IM

Jefferson

Lisa Beth Bazzett MD — OBG
Varanise Colbert Booker MD — P
Timothy Harold Camden MD — PD
Mary Elizabeth Chismarich MD — PD
Albert Wei Chow MD — PS
Leonardo Clavijo MD — IM
Kristin Denielle De Haven MD — OBG
Bahram Forouzandeh MD — GE
Sheila Denise Fugate MD — PD
Michael Kevin Hamm DO — EM
Kapil Pareek MD — U
Barbara K Pawley MD — R
William C Ralston III MD — PTH
Stephen Matthew Rose MD — ORS
Jeremy James Scobee MD — OBG
Craig K Steiner MD — PD
Sonja Kaye Terry MD — PD
Sandra Lynn Wong MD — S

DEATHS

William J. Temple, MD
Covington
1917-1998

William J Temple, MD, a retired pediatrician, died May 24, 1998. A 1943 graduate of the University of Louisville School of Medicine, Dr Temple was a life member of KMA.

Wallace A. Askew, MD
Jeffersonville, IN
1933-1998

Wallace A. Askew, MD, an ophthalmologist, died June 15, 1998. Dr Askew graduated from the University of Southern California School of Medicine and was an associate member of KMA.

Raymond M. Slabaugh, MD
Lexington
1915-1998

Raymond M. Slabaugh, MD, a retired urologist, died June 20, 1998. A 1939 graduate of Ohio State University College of Medicine, he was a life member of KMA. Dr Slabaugh was the father of Thomas K. Slabaugh, MD, KMA's Vice speaker of the House of Delegates.

Krishan K. Arora, MD
Louisville
1942-1998

Krishan K. Arora, MD, a nephrologist, died June 22, 1998. Dr Arora graduated in 1965 from Guru Nanak University and was an active member of KMA.



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Lexington Diagnostic Center ....Cover IV

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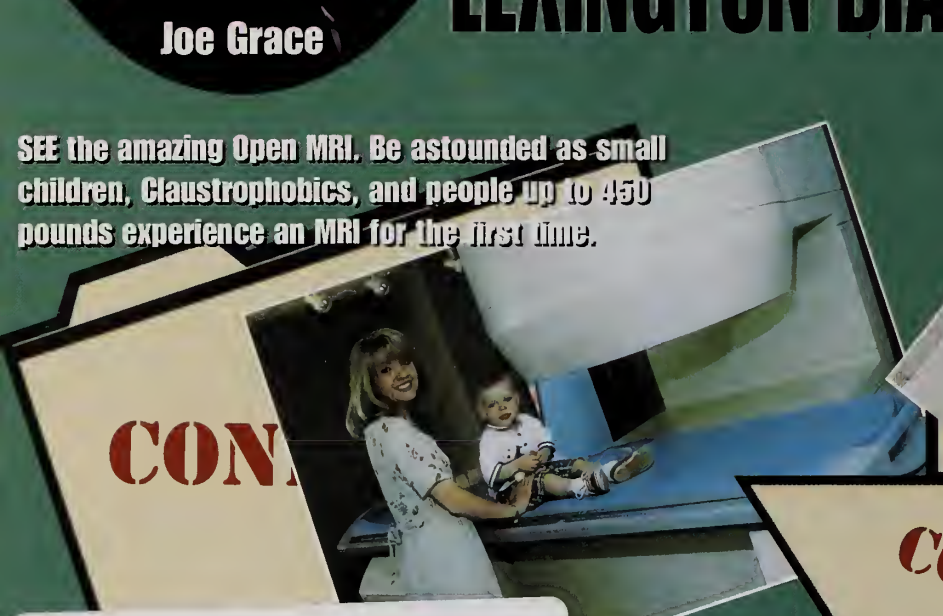
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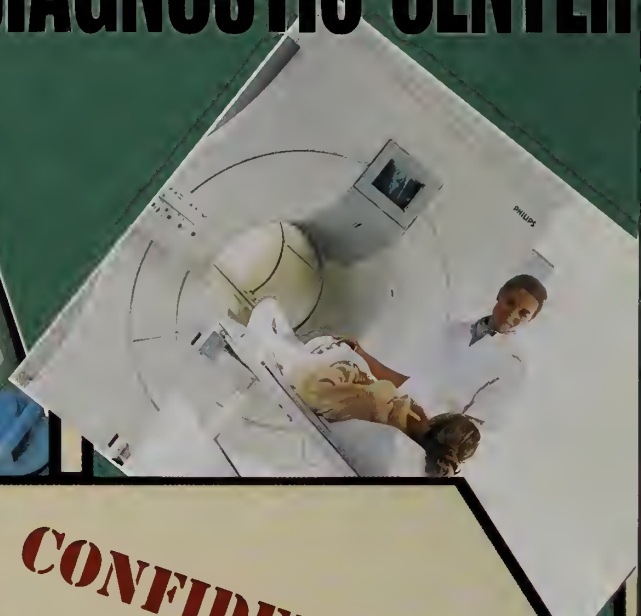
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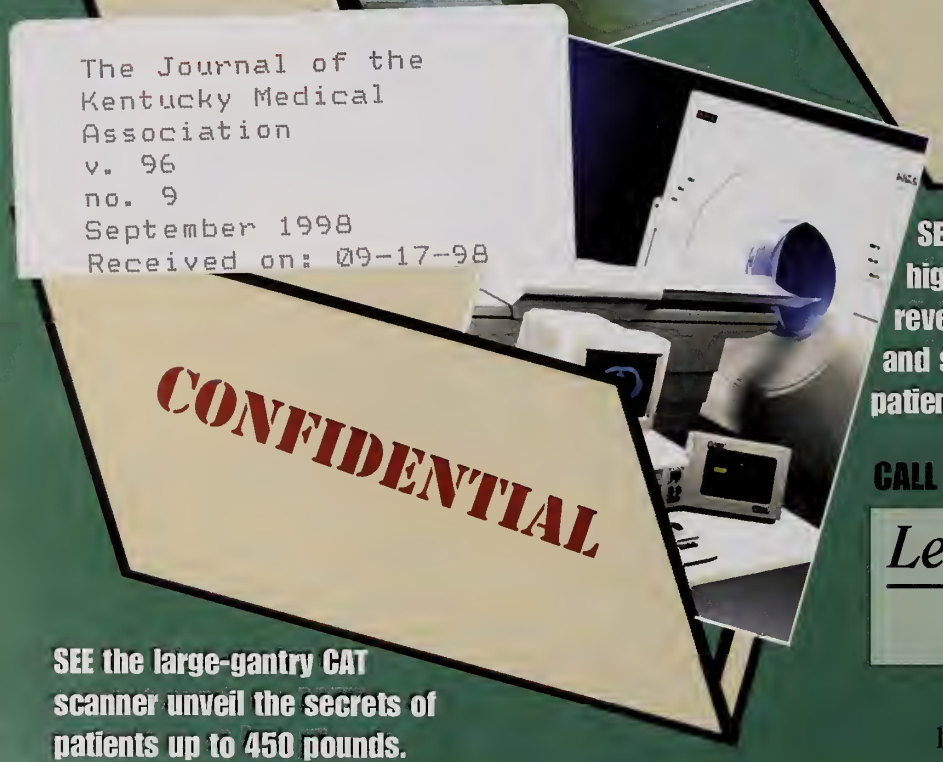
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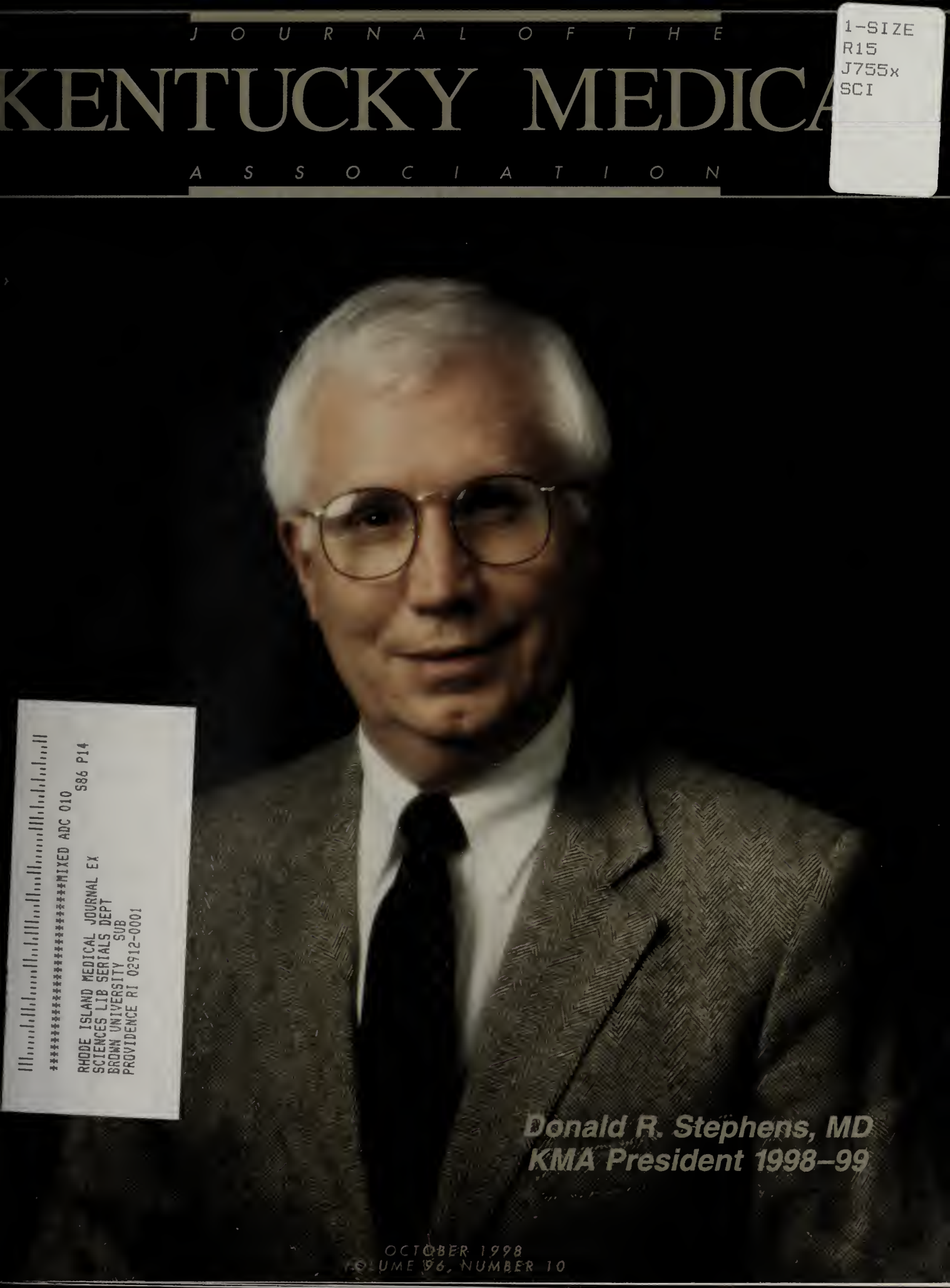
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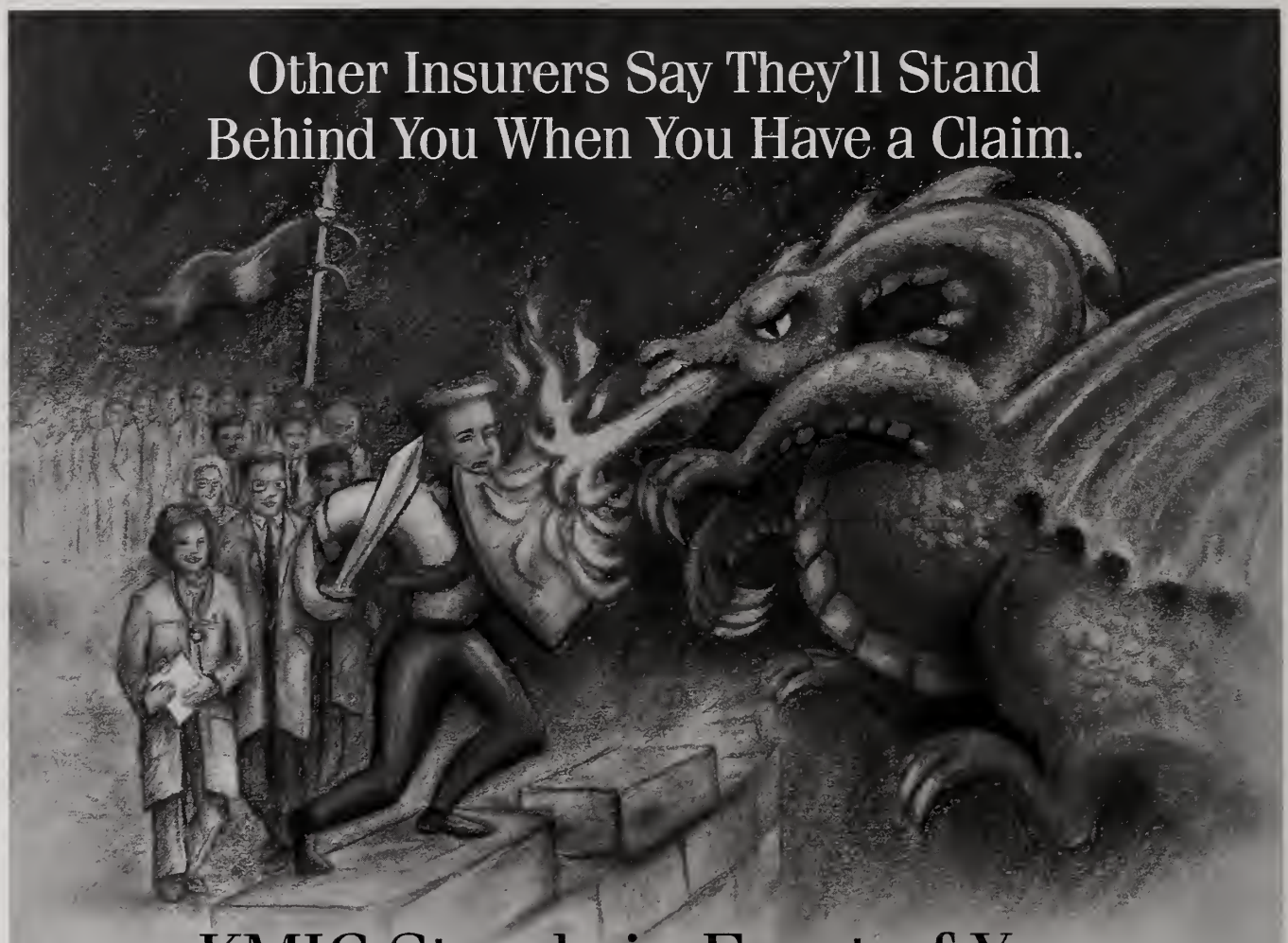


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KMA President 1998–99

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VOLUME 96, NUMBER 10 OCTOBER 1998

COVER STORY

Profile—Donald R. Stephens, MD, KMA President 1998-99 **410**
Sue Tharp

SCIENTIFIC

Rhabdomyosarcoma in Children — A Ten Year Review **399**
William B. Bradford, MD; B. Oliapuram Jose, MD, FACR; David Butler, MD; Robert D. Lindberg, MD, FACR; Kristie Paris, MD; William J. Spanos, Jr, MD, FACR; C. C. Patel, MD; Salvatore J. Bertolone, MD

SPECIAL ARTICLE

Kentucky Physicians' Perspectives and Preparedness for Computing in Medical Education and Practice **405**
Amy V. Blue, PhD; Donald Witzke, PhD; Giulia Bonaminio, PhD; Diane Fitzgerald; Mary Ramsbottom-Lucier, MD; Robert Rubeck, PhD; Lois Margaret Nora, MD, JD

EDITORIAL

Faithful Stewards... a Reflection **415**
Daniel W. Varga, MD

ASSOCIATION

Monitoring Medicine **397**
August Board Meeting **420**
Member-Get-a-Member Campaign **425**
News **422**

DEPARTMENTS

President's Page **393**
Advertisers' Guide **426**
Alliance Page **417**
Information for Authors **402**



COVER:
On September 23, 1998, Donald R. Stephens, MD, a Cynthiana family physician, was installed as the 148th President of the Kentucky Medical Association. Dr Stephens' Inaugural Address begins on page 393 and a profile of this long-time servant of medicine begins on page 410.

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Inaugural Address

Donald R. Stephens, MD



Donald R. Stephens, MD

To members of the Kentucky Medical Association, I thank you for the opportunity to serve. However, if your expectation was to elect a polished speaker, you're in trouble. My speaking skills may be akin to a former minister. According to him, he struggled mightily with his sermons. One Sunday, one of his oldest and dearest parishioners shook his hand as she left Church, leaned forward and whispered in his ear, "Congratulations preacher, every sermon you give is better than the next one."

Hopefully, by the end of the year, we can turn that around.

I recently read the following article that may have meaning to those here today. "On a night in April 1912, the majestic White Star Liner, the Titanic, making her maiden voyage, struck an iceberg in the North Atlantic and sank, taking 1500 of the 2200 people on board to their deaths. The next day, the headline in a Scottish newspaper read: 'Aberdeen Man Lost at Sea.'" That may seem a somewhat parochial view of one of the most terrible maritime disasters in history, but it is rather typical of how we see the world in its good and its bad. We tend to measure events against ourselves and judge them as they affect us and those about us. Maybe, that's how we view the medical and health delivery system in this country. Our primary concern is how it effects family, friends, and us. I recall a story years ago when an agent bragged that his health insurance company only rejected 6 tenths of 1% of claims. An old physician shot back, "Yes, but when you're one of those 6 tenths of 1% it's a 100%."

According to polls the single most important legislative issue before Congress is patient protection. The 1997 KMA House of Delegates designated Patient Protection as KMA's primary legislative goal. Most of my presentation will detail the problems brought on by managed care and their failure to address the systemic problems that existed before managed care came on the scene, and still remain. For many years, the non-profit sector, primarily Blue Cross/Blue Shield, held medical costs to reasonable levels. In the late 60s enabling laws proposed by President Nixon were adopted permitting formation of non-profit HMOs. Unfortunately, subsequent changes allowed formation of "for profit" HMOs. Once they achieved a toehold, for profit HMOs used large capital outlays to underbid traditional plans and non-profit HMOs. This marked the "beginning of the end" for Blue Cross and Blue Shield, at least for the non-profit, prepaid health insurance model that existed for 30 years. New players to the game of financing and administering health plans, for profits, soon found themselves in financial hot water. They responded by dramatically slashing provider reimbursement, added co-pays, deleted traditional HMO "wellness" benefits, and slapped annual 3-5% premium increases on their customers. They heaped enormous bureaucracy on the delivery system, which has now been expanded to three and one half bureaucrats for every physician—or as we like to say, three and a half white shirts for every white coat.

James Baldwin wrote, "the price one pays for pursuing any profession, or calling, is an intimate knowledge of its ugly side." Physicians, nurses and other medical professions empathize with Baldwin's truths. Medical professionals recognize "in a heart beat" the ugly side of health care in today's HMOs and managed care

system. From the get go, physicians warned that HMOs were ignoring traditional market forces that drive health care costs, and that the same fate that befell traditional health insurers would visit HMOs. But nobody cared, so long as the losers were physicians, hospitals, and nurses.

In the mid 90s the public began to feel the squeeze. HMOs began cutting services, reduced access, denying and delaying care, and for the first time, overruling physician decisions. The ripple effect led to dangerous reductions in nursing staffing levels and patients found themselves running all over the creation to obtain care. Drive-through mastectomies and deliveries became HMO trademarks. Patients objected and demanded protection. HMO executives ignored our protests and warnings. In fact we were dismissed as amateurs with little knowledge of the new system. Remember the old saying, "amateurs built Noah's ark, and professionals designed and built the Titanic." Over 30 states, including Kentucky, gave their responses to HMO "professionals" and adopted Patient Protection provisions to deal with HMO abuses. Thanks to Representative Bob DeWeese MD, and Representative Bob Damron, the 1998 Kentucky General Assembly enacted a broad range of patient protection/ provider fairness provisions. Unfortunately, Congress has failed to enact federal legislation to complete the circle.

The abuses of managed care lead us to an even more sobering concern. There is a growing inevitability that we are on the brink of a single source payment plan. That may be the only option remaining for health care providers and their patients to compensate for an impersonal and unbridled HMO and an intransigent Congress. We grow weary of "out-of-state physicians and nurses, by telephone and from afar" declining a needed test or service for our patients. Patients' pleas are drowned out by the giant sucking sound of health premiums' dollars compensating inept HMO executives for poor and questionable business practices, mergers, stock options, and splits. HMO executives and medical directors keep telling patients and physicians that they are working on providing phone access, reducing paperwork, speeding up approvals, paying claims more promptly, and reviewing rejections.

Ask them a question and you get the old line, "I'll get back to you." It makes you feel like a man who was bitten repeatedly by a dog whose smiling owners kept reassuring him that Fido is friendly.

The elderly, poor, children, and disabled are to a great extent adequately insured by Government. The only uninsured remaining are the working poor, patients in their 50s or early 60s who have lost their job or have poor health. Congress, large employers, and HMOs are rolling the dice, by opposing the public's will. Sooner or later, insurers will find they can't have it both ways—they can't refuse to insure the working poor and sick while campaigning to prevent a government program to cover these folks.

In a recent poll, Harris and Associates people were asked the following question. "Are the following industries doing a good or bad job serving consumers?" The public rated one industry lower than health insurance companies, HMOs, and managed care executives. TOBACCO COMPANY EXECUTIVES. HMO executives' indifference to patients reminds me of a story out of South Africa. For several months, nurses at a hospital noticed that every Friday morning, the unlucky patient in a certain bed in the intensive care unit was dead. The mystery was solved when authorities discovered that a cleaning lady, making her rounds on Friday mornings, was unplugging the life support system in order to plug in her floor polisher. She would reconnect the life support after finishing her work, but by then it would be too late. The hospital installed an extra socket and the death rate in that bed has returned to normal. We hope that Hospital Administrator didn't have to seek approval from a managed care company before they added the additional socket—it would probably have taken another week.

Let's conclude by examining managed care's track record on issues that drive health costs. Have they addressed any of the following systemic problems of our delivery system?

- Technological explosion in medicine?
- Aging Americans' impact on medical care?
- The uninsured?
- Buereaucracy of state and federal regulation?
- Paperwork maze?
- Tort reform?
- End of life issues?

The answer to all questions is NO. We have made absolutely zero progress in solving the real problems driving medical care costs. HMOs' only approach to reducing medical costs is simple. Deny, delay, or refuse to pay.

We have fought this battle for many years, and once again, it becomes physicians, hospitals, and health care providers' responsibility to reclaim our rightful roles to address reform, particularly those issues dealing with the uninsured and rising health costs. We can begin by doing the following:

- Recommit ourselves to ethical and professional behavior, stringent peer review, and zero tolerance for peers who violate the public and patient trust.
- Reassure patients that we are their advocates, committed to their care, and diagnose and treat disease to the best of our ability.
- Legislation to remove burdensome government regulations and dangerous managed care policies is long overdue.
- Principle of choice for patients must be a cornerstone of health care.

- State and national governments, employers and employees must consider new mechanisms for individual ownership and control of personal health policies by the patient, rather than the employer.
- Tort Reform to eliminate "defensive medicine" remains the cornerstone of any reform of the medical system.

While we cannot solve the problems alone, we can begin the process. We deserve recognition for our efforts, and because of our contributions and unique knowledge of the system, our views should be taken seriously.

Before I close, I want to thank the physicians of this state for their dedication. We shouldn't be shy about the positive things we do for our patients and this country.

- No organization, group, or profession can match Kentucky physicians for taking care of the poor. Most physicians quietly donate 5-10% of their practice time treating indigent non-paying patients. The Kentucky Physician Care program initiated in 1985 by KMA still has over 2000 physicians participating who agree to treat uninsured indigents at no cost. Through 1997, over 150,000 needy individuals have been certified eligible for Kentucky Physician Care.
- KMA has been on the cutting edge in addressing drug, alcohol, adult and child abuse, domestic violence, neglect, and exploitation.
- We have worked hand in hand with the KMA Alliance to address the problem of violence. The Alliance, working with the KMA Patient Education Committee has distributed thousands of booklets to our youngest and most vulnerable children teaching them to avoid violence—or as the slogan goes "hands are not for hitting."
- No organization in this state has been more supportive of education, particularly health education for our children, than the KMA Alliance, and we need to publicly recognize our spouses for their caring and dedicated efforts to improve the lot of our children.
- KMA continues to pursue health and safety legislation to require helmets on motorcycles and bike riders, outlaw children riding in open vehicles, supporting watercraft safety, immunization standards, and food and water standards.
- The KMA Physical Medicine and Sports Committee has been a leader in educating coaches and sports personnel on methods to avoid unnecessary student athlete injuries and death.
- We continue to oppose the use and sale of tobacco, especially to our youth. The KMA has adopted more policy positions on tobacco than any single issue.
- The initiation and insistence of the KMA and persistence of Representative Bob DeWeese and Bob Damron, propelled the General Assembly to adopt an outstanding Patient Protection package.
- The Kentucky Rural Medical Scholarship fund has placed over 500 physicians in rural areas of Kentucky.

But KMA works just as hard for members.

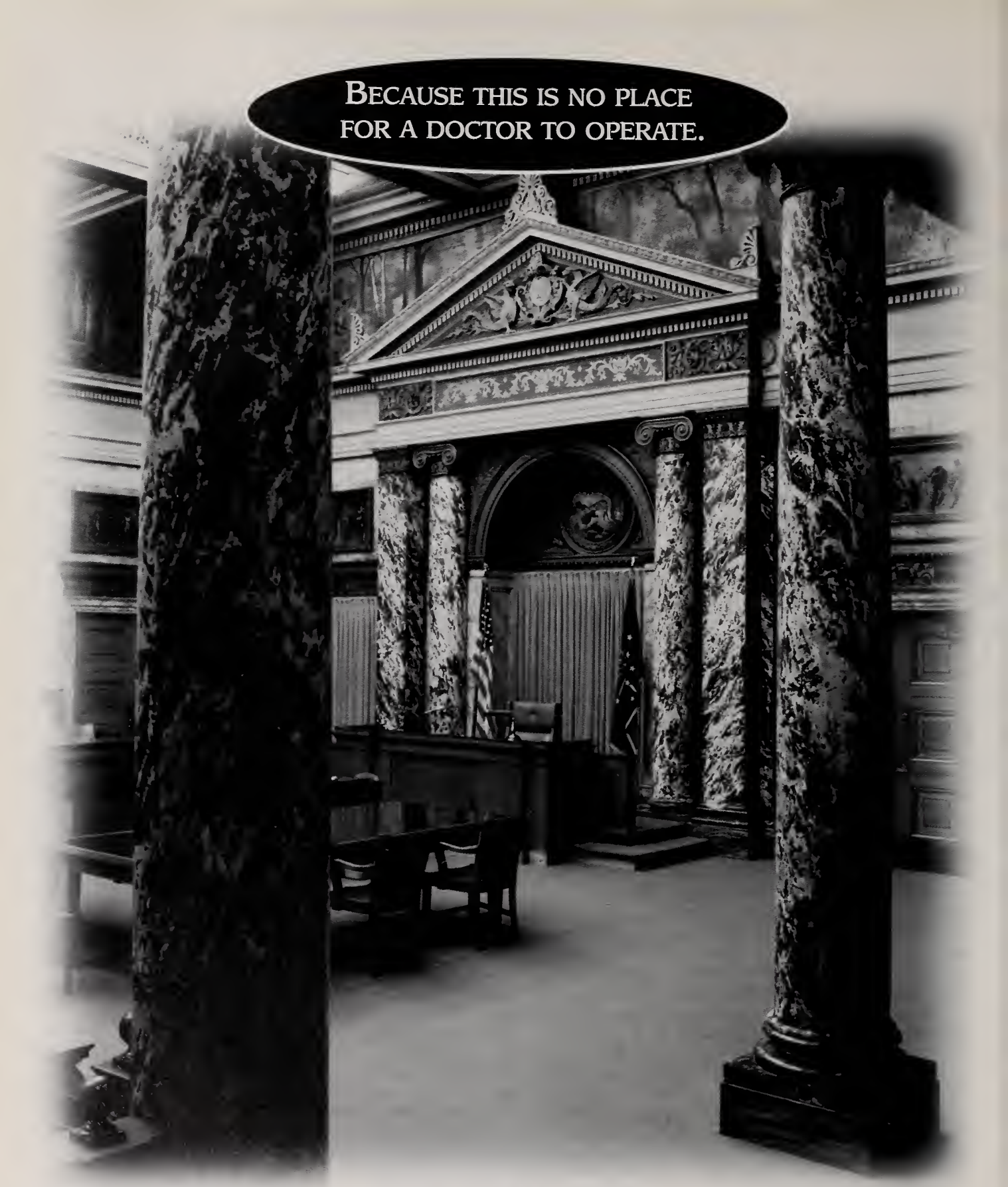
- We formed committees to discuss Women in Medicine, addressed concerns of international medical graduates, academia, and young physicians. In addition, we involve our residents and students in all levels of organized medicine.
- We have a growing number of "employed" physicians and KMA is addressing their issues, particularly as more of our young physicians choose this route.
- This Association continues its goal to reform the tort system, adopt strong patient protections, and enact appropriate health and safety legislation.
- Through Ken Peters' vision, a road map to the future has been drawn.

It has been a wonderful experience to serve with Ken Peters, my friend and classmate. Ken represents what medicine is—and what it ought to be. He has begun the process of planning that will allow us to proceed in a measured way as we move toward a new millennium. Ken has developed the plan, and it is our task to carry it out.

We can achieve success if we set our mind to it. Physicians see or talk to 75% of the US population every single year. Over 5.5 million interactions occur on a daily basis between physicians and patients. Our access to the public is unmatched by TV or any other media. Use it. So long as our goal is to help patients receive quality care they need and deserve, we can prevail on patient protection or other noble goals. In the words of James Rouse, "What ought to be can be, if we have the will to make it go."

I honestly seek your support in the coming year as we move forward in a spirit of unity and purpose.

Presented by
Donald R. Stephens, MD
as he assumed the
Presidency of the
Kentucky Medical Association
on September 23, 1998.



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NEWS FOR KENTUCKY PHYSICIANS

NOTICE TO DISPENSING PRACTITIONERS

Practitioners who dispense controlled substances will be required to report to the Cabinet for Health Services/Drug Control Branch beginning January 1, 1999. HB 115, which was passed during the 1998 General Assembly, requires the Cabinet to implement a computerized monitoring system for controlled substances dispensed within the Commonwealth. All dispensers of controlled substances (in-state pharmacies, out-of-state pharmacies and practitioners) will be required to report specific information for each dispensation. **If you dispense controlled substances, you should contact the Drug Control Branch for information about how to report.**

The data submitted will be stored in a high-security database and access to the information will be strictly limited by statute. Drug Control will use the data to identify patients who appear to be drug seekers by obtaining prescriptions from multiple practitioners and pharmacies. Also practitioners will be able to obtain confirmation that a patient is not seeing other practitioners for controlled substances.

New Prescription Blanks Required Beginning January 1, 1999

Beginning January 1, 1999, security prescription blanks will be required for all prescriptions written for **controlled substances**. Special blanks will *not* be required for drugs that require a prescription but are not classified as narcotics or controlled drugs.

For example, security prescription blanks will be required for:

- Percocet, Tylox
- Demerol
- Lorcet, Lortab, Vicodin
- Tylenol with Codeine
- Xanax, alprazolam
- Valium, diazepam
- Soma
- Anabolic steroids
- Most appetite suppressants including Meridia
- Stadol NS

Alternatively, security prescription blanks will **not** be required for:

- Antibiotics
- Hormones, other than anabolic steroids
- Most antihypertensives
- Antidepressants such as Elavil, Prozac, Zoloft, trazodone, Effexor, or Paxil
- Antihistamines
- **The majority of prescription drugs**

What You Need to Know

- Sources for security prescription blanks will be provided to practitioners.
- Security prescription blanks deter forgery or alteration of prescriptions.
- Only one drug can be prescribed on one security blank. Use multiple blanks to prescribe multiple controlled substances.
- Telephone prescriptions are still permitted for drugs in schedule III, IV or V. (Ky law does NOT recognize emergency prescriptions for schedule II drugs)
- Prescriptions that are faxed to a pharmacy must be written on a security blank. (Schedule II prescriptions may be faxed ONLY if (a) the patient is in a long-term care facility or a Hospice program or (b) the drug is a parenteral narcotic that must be compounded by a pharmacist.)
- Waivers are available for practitioners or pharmacies that use alternative systems that prevent forgery and alteration.

For further details, contact the Drug Control Branch in the Department for Public Health at (502) 564-7985 or fax (502) 564-2203.

CONSIDERATIONS WHEN PRESCRIBING BENZODIAZEPINES

Benzodiazepines are effective and safe medications for many medical and psychiatric conditions. Some of the most obvious appropriate indications include their use as an agent for conscious sedation, use as an anticonvulsant, time-limited use as a hypnotic, and use as a treatment for acute states of anxiety associated with a major life event. A psychiatrist might also prescribe benzodiazepines to control acute agitation, for akathesia, or as an adjunct to an antidepressant. Difficulties occur when questions of substance abuse and chemical dependency are at issue. The Board also recognizes that inappropriate prescribing of benzodiazepines may lead to drug diversion and abuse by individuals who seek the medications for other than legitimate use. Some Kentucky physicians have asked for reference guidelines which could be utilized in day to day practice and when communicating with patients.

The first principle to observe is the clear documentation of the patient's Medical, Psychiatric, Chemical Dependency, Family and Psychosocial histories. Subsequently, a treatment plan needs to be developed and included. Appropriate aspects of the physical and mental status examinations should be included in the initial evaluation.

The benzodiazepines are primarily used for the alleviation of acute symptomatic relief of anxiety and insomnia, or for the detoxification from sedative hypnotics, alcohol, or the benzodiazepines themselves. Generally speaking, when prescribing for acute psychiatric symptoms, the physician should plan for no more than three months of the benzodiazepines allowing for a period of gradual taper prior to discontinuing the medication.

Psychiatrists acknowledge there are those individuals with primarily Anxiety Disorders who can be effectively managed with long term benzodiazepines without developing drug tolerance. As a psychiatrist makes this clinical decision, the physician would be expected to document the following considerations:

1. Is the Psychiatric Diagnosis correct? That is, does the patient have a chronic Anxiety Disorder such as Panic Disorder with or without Agoraphobia, a Phobic Disorder, Obsessive Compulsive Disease.

2. Does the patient have a history of Chemical Dependency or a Family History of such? The concern here is the fear of possibly kindling Drug Abuse/Dependency.

3. Have other treatment interventions been tried unsuccessfully such as the antidepressants, psychotherapy, Cognitive or Behavior Therapies?

4. Have co-existing medical diagnosis such as Mitral Valve Prolapse or Thyroid dysfunction been ruled out?

5. Are there any indications that the patient might not be forthright and will the patient agree to the one doctor — one pharmacy doctrine? Interviewing a significant other can frequently be helpful in this regard.

6. Has a long acting benzodiazepine such as Clonazepam been given a preferential trial over a benzodiazepine with a short duration of action?

7. Has there at some point been a documented discussion with the patient of the risk of developing tolerance to the benzodiazepine and that patients can become psychologically and possibly physically dependent on these medications? When and if this became apparent, the medication would have to be discontinued gradually.

8. Have there been documented periodic reviews of treatment goals without indications of adverse clinical correlates?

While these guidelines are not intended to define practice standards, for the non-psychiatric physician to embark or continue to prescribe benzodiazepines for an extended period of time is generally not a prudent clinical decision. Requesting the consult of a psychiatrist is appropriate and one should feel free to refer to the brief outline of the patient resists.

Submitted by C. William Briscoe, MD. Adopted by Kentucky Board of Medical Licensure 06-18-98.

Rhabdomyosarcoma in Children—A Ten Year Review

William B. Bradford, MD; B. Oliapuram Jose, MD, FACR; David Butler, MD; Robert D. Lindberg, MD, FACR; Kristie Paris, MD; William J. Spanos, Jr, MD, FACR; C. C. Patel, MD; Salvatore J. Bertolone, MD

PURPOSE: The purpose of this study is to retrospectively analyze all pediatric patients with Rhabdomyosarcoma (RMS) of various anatomic sites, treated in our department over a 10-year period, for treatment results. Anatomical site, group, and gender are individually analyzed as prognostic indicators of overall survival.

MATERIALS AND METHODS: Sixteen rhabdomyosarcoma patients diagnosed by biopsy or surgical resection were reviewed. All patients were treated according to assigned IRS protocols except one. Age ranged from 1 to 19 years with a median age of 4 years. Ten patients were male and 6 were female, 14 were white and 2 black. Anatomic sites included six from the head and neck region, seven in the trunk and three in the extremities. Embryonal RMS was present in all but one which was classified as undifferentiated. All patients had surgery (biopsy-5, partial-1 or complete resection-10) and chemotherapy (VA, VAC, VAC plus Adriamycin, or VAC plus Adriamycin, CIS Platinum and VP-16). Ten patients received irradiation consisting of 3060 cGy to 5850 cGy using shrinking fields with 1.8 to 2.0 Gy/day/5 day/wk.

RESULTS: Patients tolerated the treatment well and there were no late complications. Only one patient had a recurrence in the primary site with a median follow-up of 61 months (range 5-118 months) for the whole group. The 5-year disease free survival and actuarial survival for all patients treated were 73% and 87% respectively, with four patients developing metastasis and three of those dead of disease.

CONCLUSION: This study represents a heterogenous group of patients with RMS treated over a 10-year-period. The results correlate with those found in the most recent published IRS data for embryonal histology. From experience gained from earlier studies, newer IRS protocols have tailored treatment protocols to specific site with more intense therapy used for difficult treatment sites.

Rhabdomyosarcoma (RMS) is the most common soft tissue sarcoma in children. It represents between 5% and 15% of all malignant solid tumors and 4% to 8% of all cases of malignant disease in children under 15 years of age.[1] RMS ranks seventh among the malignant neoplasms of childhood, preceded by leukemia, tumors of the central nervous system, lymphoma, neuroblastoma, Wilms' tumor, and bone cancers.[1] The annual incidence rate of RMS in the US is estimated to be 4.4 per million in white children and 1.3 per million in black children under age 15. There is a slight male predilection with male:female ratio 1.4:1.[2]

The most common anatomic sites affected in terms of frequency are head and neck, including the orbit (38%), genitourinary tract (21%), extremities (18%), trunk (7%), retroperitoneum (7%), the intrathoracic region (3%), the gastrointestinal-hepatobiliary tract (3%), the perineum and anus (2%), and other sites (1%).[3]

Head and neck, genitourinary, and orbit are favorable sites, with a 3-year survival of 94%, whereas parameningeal, extremities, trunk, retroperitoneum, and other sites are unfavorable with survival of only 65% to 70%.[4]

The four classical histologic types of childhood RMS are alveolar, embryonal, embryonal-botryoid, and pleomorphic.[3] Embryonal histologic features occurred in 56% of the patients in IRS-1 and is most commonly found in head and neck and genitourinary sites. Alveolar histologic features occur in 20% of the patients and is the second most common pathologic type. The trunk, extremities, and perineal region are the most common sites for the alveolar type and occur more frequently in teenage children. The botryoid histology is thought to be a variant of the embryonal form and occurs in any submucosal site. These are found most frequently in the genitourinary system or head and neck region. The pleomorphic or adult form of RMS is rare in childhood and occurs in only 1% of cases and are usually located in the

From the University of Louisville Department of Rodiotion Oncology, Brown Concer Center (Drs Brodford, Jose, Butler, Lindberg, Poris, ond Sponos) ond the University of Louisville Division of Pediotric Hemotology & Oncology, Kosoir Children's Hospital (Drs Potel ond Bertolone).

Table 1. Patient Statistics: Pediatric Rhabdamyasarcama

Na.	Pt	Age (Yrs) Sex/Race	Anatamical Site	Graup	Surgery	Chematherapy	XRT (cGy)	Status/Survival (manths)
1.	MS**	1.3/F/B	Abdamen	1	Camp Resec	VAC,AD,CIS-P VP16,IRS-III	Nane	P/1
2.	RH	3.5/M/W	ABD/Pelvis	1	Camp Resec	VAC,IRS-1	4500(a)	DM/21
3.	CM	4.5/F/W	ABD/Pelvis	1	Camp Resec	VAC,IRS-II	4000(c)	P/28
4.	MB	3.9/M/W	Bladder	1	Camp Resec	VAC,IRS-II	Nane	NED/130
5.	BB	2.5/M/W	RT Paratid	1	Camp Resec	VA,IRS-III	4140	NED/38
6.	GH	.13/M/W	Right Hand	1	Camp Resec	VA,IRS-III	Nane	NED/61
7.	JH	3.3/M/W	Lft Ext Ear CNL	1	Camp Resec	VA,IRS-III	Nane	NED/62
8.	MJ	4.3/M/W	Paratesticular	1	Camp Resec	VA,IRS-III	3060	NED/42
9.	PR	19.3/M/W	Paratesticular	1	Camp Resec	VAC,AD,CIS-P, VP16,IRS-III	4440(d)	DM/61
10.	EL*	9/M/W	Pelvis	I	Camp Resec	Intrathecal MTX	5850(b)	DM/5
11.	TW	8.7/M/W	Intfra Tem Fassae	II	Part Resec	VAC,AD,CIS-P, VP16,IRS-III	4500(e)	P/38
12.	CD	2.1/M/B	Right Faat	III	BX Only	VAC,IRS-II	4140	NED/82
13.	CG	4.8/F/W	Orbit	III	BX Only	VAC,AD,IRS-II	4600	NED/113
14.	MC	9.1/M/W	L Lawer Ext	III	BX Only	VA,IRS-II	Nane	NED/81
15.	AF	10.2/F/W	Lft Max Ant	III	BX Only	VAC,AS,CIS-P, VP16,IRS-III	4980	NED/57
16.	JW	1.1/M/W	Nasapharynx	III	BX Only	VAC,IRS-II	5040	NED/120

* Undifferentiated sarcama
** Excluded fram analysis
NED = Na evidence af disease
P = Dead af primary disease
(a) Metastatic disease ta lawer extremity treatment with add 68GY
(b) Metastatic disease ta brain and cervical spine treatment with add 24GY and 23GY respectively
(c) Develaped recurrence within the irradiated field, na add treatment
(d) Brain metastasis, rejected, na further treatment
(e) Develaped recurrence just autside irradiated field treatment with add 45GY and 35GY

extremities and trunk. Histology, as single prognostic factor, was analyzed from the IRS-1 and IRS-2 from a total of 1626 cases, with botryoid, embryonal, alveolar, and, undifferentiated having 85%, 66%, 53%, and 57%, 3-year survival, respectively.[5]

The overall cure rate for children and adolescents with RMS has improved from 55% in IRS-1 to approximately 65% in IRS-II with increases in cure rate due to multimodality therapy.[6] Intergroup studies subsequent to IRS-1 (IRS-II in 1978, IRS-III in 1984, IRS-IV in 1988) have adjusted treatments (surgery, chemotherapy, and radiation) in accordance with specific sites and histologies with significant increases in survival. The results of IRS-III show the target gain in overall survival is in patients with gross residual tumor after biopsy (clinical group-3).[11] The present study represents a single institution's experience with treatment of pediatric RMS over a 10-year period with treatment as outlined by either IRS-I, IRS-II, or IRS-III.

Materials and Methods

The study consists of 16 patients diagnosed with RMS treated from 1978 thru 1988 at Kosair Children's Hospital in Louisville, Kentucky. The patients were treated according to IRS (I-III) protocols over the 10-year period and were assigned to various protocols on basis of tumor site and/or high risk histology. Of the 16 patients considered for this study, only 15 were used for analysis, since 1 patient (#1) died of progressive disease within 1 month following the completion of treatment. The median age of the patients was 4 years with a range of 1 to 19 years and a male to female ratio of 2:1. Of the evaluable patients, 14 were white and 1 black (female). General anatomical sites included six in the head and neck region, six in trunk, and three in extremities with all histologies being embryonal except for one which was classified as undifferentiated (Table 1). Pathological analysis was done at the treatment institution, with

clarification of one specimen by Armed Forces Institute of Pathology. Nine patients had complete resection (group 1), one had partial resection (group 2), and five had biopsy only (group 3). Chemotherapy regimens used are as listed and were administered per specific IRS protocol. The dose of irradiation (10 patients) ranged from 40 GY to 59 GY using shrinking fields with 1.8 to 2 GY/day/5 days/week. Survival was calculated from date of diagnosis to date of last follow up or date of death. BMDPT and Kaplan-Meier statistical programs were used for generating statistical data. Calculation of p-value data was done utilizing the Mantel-Cox (Generalized Salvage) statistical calculations.

Results

All patients are eligible for a minimum of 48 months follow up. Median follow up for all patients was 61 months with a range of 5-118 months, and four patients of the 15 are dead of disease. Survival by site ranged from 5 months to 118 months with 5 year disease-free and actuarial survival being 72% and 87% respectively (Figure 1). Head and neck, truncal, and extremity lesions had an actuarial survival of 80%, 50%, and 100%, respectively (p=.15). Analysis by type of surgery was done with group I (9 patients-complete resection) having actuarial survival of 63%, and group II and III (partial 1 patient-resection and 5 patients-biopsy) having an actuarial survival of 83% (Figure 3). However, the difference in survival was not significant with P=.36. Females and males had actuarial survival of 80% and 69% respectively (P=.69) (Figure 4) Three patients (#2, 9, 10) developed metastatic disease either during or after primary therapy was completed, with all three dead of disease. One patient (#3) who underwent complete resection and post-op XRT with chemotherapy recurred within the irradiated field, and another patient (#11) underwent partial resection with post-op XRT recurred just outside the irradiated field. All other patients in the study had good local disease control with patients tolerating treatments well. There were no major complications encountered in this study group.

Discussion

This study, which comprises patients from the first three IRS studies, was done to analyze one institution's experience with the treatment of pediatric RMS over a 10-year period. The overall survival of this group correlates with that found in the most

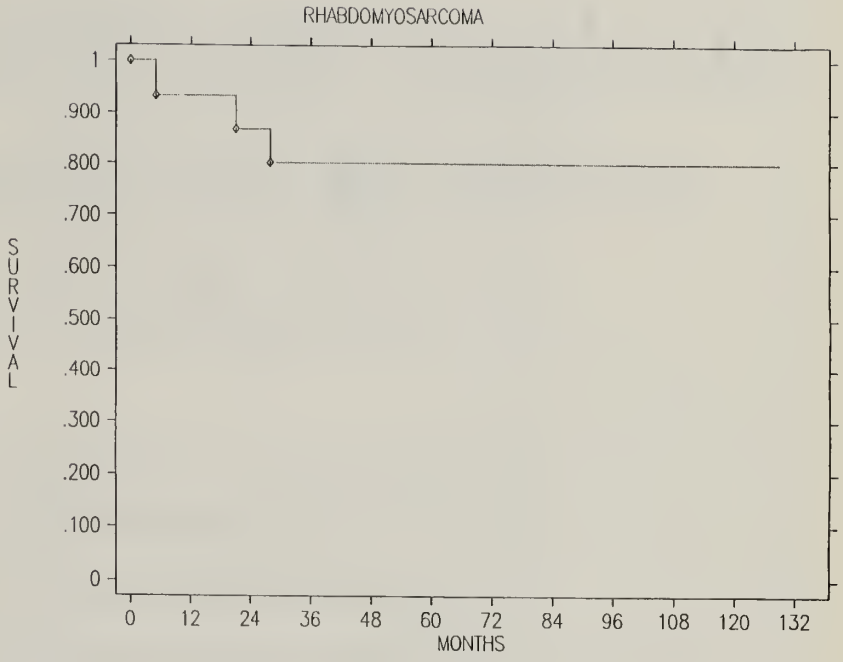


Figure 1

recently published IRS data for embryonal histology.[5] However, survival figures obtained for site and group are contrary to those found in the IRS studies. As stated above, this was a limited study. Survival differences within the two stratifications were not found to be significant. The results obtained here do reflect the trend of improving survival shown in successive IRS studies.[7] Large increases in overall survival have been seen in successive IRS study groups primarily due to alterations in chemotherapy protocols and regimens. There have been changes in therapeutic approaches since IRS-I began accruing patients in 1972, including changes in new chemotherapy regimens for the more aggressive histologies and anatomical sites of disease presentation.

Current IRS-IV protocols include VAC, VAI (vincristine, actinomycin-D, ifosfamide), or VIE (vincristine, actinomycin-D, etoposide) induction and maintenance, as well as randomization to either hyperfractionated or conventional radiotherapy. VAC chemotherapy, as demonstrated in IRS I and II protocols, demonstrated improving survivals with more intense chemotherapy programs (Repetitive pulse vs pulse) with Group III and IV patients but with attendant increase in myleotoxicity. Even with increased myleotoxicity, however, patients received 75% of prescribed dose of chemotherapy.[2] In International Society of Pedi-

atric Oncology (SIOP) trials, VIA was proven to be an effective chemotherapy regimen, with ifosfamide having activity similar to cyclophosphamide but with much less myleotoxicity. The use of Mesna has virtually eliminated bladder toxicity in European trials.[8] Etoposide (VP-16) has also been previously shown to be effective in RMS and undifferentiated sarcomas.[9] IRS IV does utilize hyperfractionated radiotherapy, since previous IRS studies have demonstrated increased local failure rate in Group III and IV disease which was independent of what conventional RT does.[9,10]

References

1. Young JI, Miller RW. Incidence of malignant tumors in US children. *J Pediatr.* 1975;86:254.
2. Maurer HM, Moon T, Donaldson M, et al. The intergroup rhabdomyosarcoma study: A preliminary report. *Cancer.* 1977; 40:2015-2026.
3. Horn RC, Enterline HT. Rhabdomyosarcoma: A clinicopathological study and classification of 39 cases. *Cancer.* 1958;11:181-199.
4. Ruymann FB. Rhabdomyosarcoma in children and adolescents. *Hematol Oncol Clin North Am.* 1987;1(4):621-654.
5. Newton WA, Soule EH, Hamoudi AB, et al. Histopathology of childhood sarcomas intergroup rhabdomyosarcomas studies I & II: Clinocopathologic correlation. *J Clin Oncol.* 1988;6:67-75.
6. Maurer HM, (For the IRS Committee of CCSG and PGO): Intergroup rhabdomyosarcoma study (IRS-II): A preliminary report. (Abstract) *Proc ASCO.* 1983;2:70.
7. Maurer HM, Donaldson M, Gehan EA, et al (For the IRS Committee): The intergroup rhabdomyosarcoma study; update, November, 1978. *Natl Cancer Inst Monogr.* 1981;56:61-68.
8. Otten J, Flamant F, Rodary C, et al. Effectiveness of combination of ifosfamide, vincristine and actinomycin D in inducing remission in rhabdomyosarcoma in children. (Abstract) *Proc ASCO.* 1985;4:236.
9. Chard RL, Krivit W, Bleyer WA, Hammond D. Phase II study of VP-16-213 in childhood malignant disease; CCSG report. *Cancer Treat Rep.* 1979;63:1755.
10. Rodary A, Rey D, Olive F, et al. Prognostic factors in 281 children with nonmetastatic rhabdomyosarcoma (RMS) at diagnosis. *Med Pediatr Oncol.* 1988;16:71-77.
11. Crist W, Gehan EA, Ragab AH, et al. The Third Intergroup Rhabdomyosarcoma Study. *J Clin Oncol.* 1995;13:610-630.

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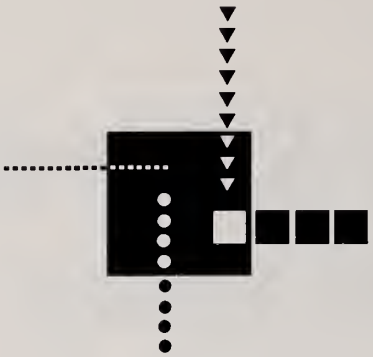
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Kentucky Physicians' Perspectives and Preparedness for Computing in Medical Education and Practice

Amy V. Blue, PhD; Donald Witzke, PhD; Giulia Bonaminio, PhD; Diane Fitzgerald; Mary Ramsbottom-Lucier, MD; Robert Rubeck, PhD; Lois Margaret Nora, MD, JD

PURPOSE. To examine the University of Kentucky College of Medicine's community-based faculty's (CBF) perspective on computing skills that students should acquire for future medical practice, and if the CBF currently use these skills in their daily practice.

METHODS. A survey was mailed to 281 of the institution's CBF in the spring of 1997. The survey listed eight basic computing skills derived from our computing curricular objectives for students and asked respondents (a) if they use the skill, and (b) if students should learn the skill.

RESULTS. 200 respondents returned a completed survey. 14 CBF (7.2%) indicated that they have all eight computer skills while 91 CBF (46.4%) indicated that students should learn all eight computer skills. 25 CBF (13%) indicated that they have none of the computer skills, while none of the CBF indicated students need none of the skills. A significant difference between primary care CBF and other specialist CBF was found with respect to self-report of computer use, but not regarding their opinions about students' need to learn computer skills.

CONCLUSION. The majority of our CBF report using at least one computer skill in their practices. Regardless of specialty, CBF report that students should possess more computer skills than they themselves have. Medical educators should incorporate computing applications into the curriculum to provide appropriate computer training for future physicians.

The role of computing in medical education and clinical settings has expanded tremendously with new developments in technology, educational software program development, and the advent of the Internet and World Wide Web. Computer assisted instruction/computer based instruction (CAI/CBI) applications have been developed with relevance to medical education and the World Wide Web has numerous educational offerings pertinent to physician training.[1-4] Computing applications in medical practice have emerged as essential for office management, clinical information access, patient education, clinical decision-making, communication, and continuing education.[5]

The need to train future physicians in the development of computer skills for medical practice becomes curricularly relevant during the years of clinical training when students can embrace these skills within a clinical context and/or observe clinicians using them. At the University of Kentucky College of Medicine (UKCOM) the presence of computing applications in the basic science curriculum is well established with students using computer-assisted instructional programs in several courses, Internet resources as supplemental learning material, and electronic mail to communicate with instructors. However, the role of academic computing in the clinical years of the curriculum is complicated by the institution's requirement that all students participate in an off-site third-year primary care clerkship for one month, and at least one off-site rotation in the fourth year. While the academic medical center has the infrastructure to support student, faculty, and staff computing activities, our community-based physicians are not connected to a single computing network and the type of computing infrastructure in their offices varies with each office practice.

UKCOM developed a set of basic computer skills that students would acquire/refine and use throughout our curriculum. We conducted a survey of practicing physicians, our community-based faculty, to provide external validation for this set of computer skills. The purpose of this study was twofold: (1) to examine our community-based faculty's perspectives on computing skills that students should acquire for future medical practice, and (2), to determine if the community-

From the University of Kentucky College of Medicine Office of Academic Affairs (Drs Blue, Witzke, Rubeck, Nara); Department of Surgery (Dr Blue); Department of Pathology and Laboratory (Dr Witzke); Chancellor's Office (Ms Fitzgerold); Department of Internol Medicine (Dr Romsbottom-Lucier); Department of Neuralogy (Dr Nara); ond the University of Konsos School of Medicine Department of Fomily Medicine (Dr Bonaminio).

based faculty presently use these skills in their daily practice.

Methods

A survey was mailed to 281 of 746 UKCOM community-based faculty (CBF) who had active voluntary faculty appointments as of December 1996. Kentucky has seven Area Health Education Centers (AHEC), which serve CBF in their regions. Before random sampling of subjects, CBF were assigned to one of four groups based on their involvement with students during the 1995/96 academic years and on their location (AHEC region versus non-AHEC region). The groups were: (1) AHEC CBF who had students, (2) AHEC faculty CBF who had not had students,(3) Non-AHEC CBF who had students, and(4) Non-AHEC CBF who did not have students. Subjects in groups 1, 2, and 4 were randomly sampled. All subjects in group 3 were selected for participation in the survey because the total size was small (n=18) and it was desired to have sufficient representation from this CBF group. At our institution, the majority of our students participate in AHEC off-site educational experiences and this fact accounts for the small number of CBF in the non-AHEC area that had had students.

An instrument was created to assess the CBF members' use of skills associated with computing in their practices and their opinions about whether students should learn these skills to be successful practicing physicians. The items on the instrument derived from the set of basic computer skills developed by our college's academic computing committee as computer skills that students should use in the medical curriculum. These skills were: (1) operating a computer (ie, backing up essential files, sharing files across platforms and applications); (2) word processing (ie, formatting text font, size and style, combining documents/moving text); (3) ethical issues involved in computing (ie, patient confidentiality); (4) electronic communication (ie, send/receive letters and attachments); (5) browsing the World Wide Web (ie, searching with search terms, bookmarking); (6) Medline searching on the Internet; (7) creating presentations (ie, making graphic presentations, slides); and (8) creating patient and laboratory database skills (ie, creating databases, accessing hospital records). Respondents were asked to indicate "yes" or "no" if they used each skill, and if they felt the skill was necessary for current medical students to learn. The instrument also contained demographic questions that asked the respondent's gender, age, race, year of graduation from medical school, practice specialty, and practice location. The survey had been pre-tested on course directors before distribution to the CBF members.

Descriptive statistics were performed for the demographic variables. Respondents were assigned to four age groups defined by quartiles. We created a primary care classification for respondents' practice specialty that designated Family Practice, General Internal Medicine and Pediatrics as "Primary Care" and all other specialties as "Other Medical Specialties."

The computer skills were combined into similar functions based on the theoretical use of these skills. This was done to create four index variables These indices consisted of an (1) overall index consisting of all eight items; (2) "Patient Care Skills," consisting of ethical issues involved in computing, e-mail skills, browsing the World Wide Web, Medline searching on the Internet, and patient and laboratory database skills; (3) "Education Orientation Skills," consisting of browsing the World Wide Web, Medline searching on the Internet, presentation skills; and (4) "Office Management Skills," consisting of operating a computer, word processing skills, e-mail skills, and patient and laboratory database skills. For each index, the percentage of skills used by the respondents was created. In a similar fashion, the percentage of skills the respondents believe students should learn was created for each index. Analysis of Variance (ANOVA) controlling for age and specialty (four age groups; primary care/other specialty) was computed for each index variable.

Results

Two hundred respondents completed surveys, and 8 were returned from retired or deceased physicians, for an overall response rate of 208 (74%). The majority of respondents were male (84%), and Caucasian (90%). The age range of respondents was 29-82 years. The age group quartiles were defined as 29-39 years, 40-44 years, 45-53 years, and 54-82. The earliest graduation year from medical school was 1939 and the latest year was 1993. Fifty-three percent of the respondents were in primary care specialties and 47% were in other medical specialties.

When the respondents' demographic characteristics (ie, AHEC location, Statistical Metropolitan Area (SMA) location, and if they had a student)

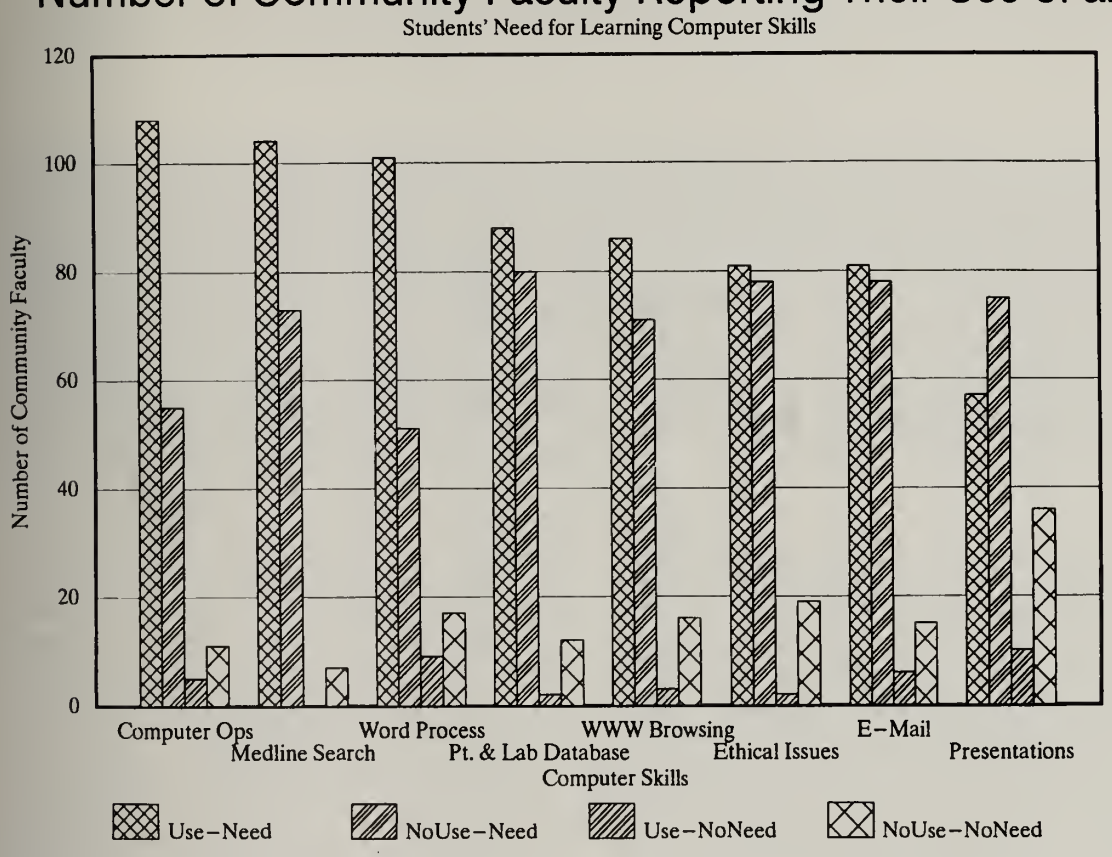


Figure 1

were compared with the sample characteristics, no significant differences were found between the two groups. Cronbach's alpha was used to determine the reliability of each index. The reliability of the eight "use skill" items was .79; the reliability of the eight "students need" items was .72. The three other "use skill" indices had the following reliabilities: patient care .71, education orientation .59, and office management .71. The three other "students need" indices had the following reliabilities: patient care .61; education orientation .41, and office management .55.

One-hundred eighty-three of 200 respondents made responses to all eight self-report use computer skill items. One-hundred fifty-three of 200 respondents made responses to all eight students should learn computer skill items. Fourteen CBF (7.2%) indicated that they have all eight computer skills while 91 CBF (46.4%) indicated that students should learn all eight computer skills. Twenty-five CBF (13%) indicated that they have none of the computer skills. Importantly, none of the CBF indicated that students needed none of the eight skills. There were no differences between AHEC and non-AHEC CBF with respect to their use of computer skills or their opinion as to whether students should learn computer skills. Figure 1 presents the frequencies of paired CBF responses to use skills and students need computer skills.

Overall, primary care CBF were significantly ($p=\leq.05$) less likely to report self-use of the computer skills than were other specialist CBF. Table 1 presents the percent computer skills used by primary care CBF and other specialist CBF. Both

Table 1. Community-based Faculty (CBF) Self Report of Percent of Computer Skills Used

Computer Skill Index	Primary Care CBF	Other Specialist CBF	
Patient Care	45.1%	54.3%	p=≤.009*
Education Orientation	42.2%	53.3%	p=≤.013
Office Management	50.4%	60.4%	p=≤.007
Overall	45.9%	56.4%	p=≤.001

* Between groups ANOVA conducted

Table 2. Community Based Faculty (CBF) Self-Report of Percent of Computer Skills Used and Percent of Skills Students Need to Learn

Computer Skill Index	CBF Use	Students Need to Learn Skill	
Patient Care	49.4%	91.5%	p=≤.001**
Education Orientation	47.7%	87.2%	p=≤.001
Office Management	55.2%	88.7%	p=≤.001
Overall	50.7%	87.9%	p=≤.001

** Within subjects ANOVA conducted

the primary care CBF and other specialist CBF indicated that students need significantly more computer skills than they themselves have. Table 2 presents CBF self-report percent of computer skills used and the percent of computer skills they think students should learn. There were no significant interactions between age and specialty by computer use and whether students needed skills. For the overall computer skill index, the patient care index, and the office management index, AHEC CBF has slightly fewer skills than non-AHEC CBF and tended to perceive that students need skills more than the non-AHEC CBF. This interaction was significant at the p=≤.05 level.

Discussion

UKCOM CBF think that students should have at least one computer skill, and preferably, they should possess almost 90% of the computer skills surveyed. Regardless of respondent age and specialty, CBF report that students should possess more computer skills than they themselves have. This finding serves as an external validation of the institution's efforts to develop an academic computing curriculum and to provide students relevant educational computing activities throughout their training. Furthermore, they confirm that medical educators should incorporate computing applications within the curriculum.[9]

The majority of our CBF indicate that they use one or more of the surveyed computer skills in their clinical practices. They report the use of approximately 50% of the computer skills pertinent to their office management, patient care activities, and educational activities. Reports in the literature vary about physicians' computer knowledge and skills. Debehnke and Valley[6] report that Emergency Medicine faculty members and residents have adequate access to computers, but have had little computer training. Vincent and Schneeweiss[7] found that 73% of family physicians in their study reported using a computer in their practice. Jones et al[8] surveyed radiology residency programs and found that 61% have computer facilities within the department. There appear to be no reports in the literature of community-based physicians' use of computer skills, thus highlighting the significance of this study to medical educators. It is of interest that our primary care CBF report using fewer computer skills than do our other medical specialty faculty. The reasons for this difference are unclear and remain to be explored. This difference may be because of differences in practice organizations (group versus solo versus hospital-based practitioner) or age.

The finding that our primary care CBF use computer skills less than the other specialty CBF is of importance with respect to medical student education. With the increased emphasis upon generalist training for medical students, and concurrently, ambulatory experiences for students, many institutions, such as UKCOM, are sending students into community-based practices for primary care rotations. The development of off-site academic computing support is an important infrastructure issue that institutions currently face. The findings from this study suggest that faculty development with computing in primary care offices may be required to enhance the students' educational experience at these sites. AHEC offices may wish to partner with academic centers in providing faculty development programs related to computing for community-based faculty. Importantly however, our findings also indicate that primary care CBF perceive the value in students' acquisition of skills that they themselves do not possess, and thus one can conclude that they will support students' computer learning efforts within their primary care clinical settings.

Sampling the results of the demographic comparisons (AHEC location, MSA location, and

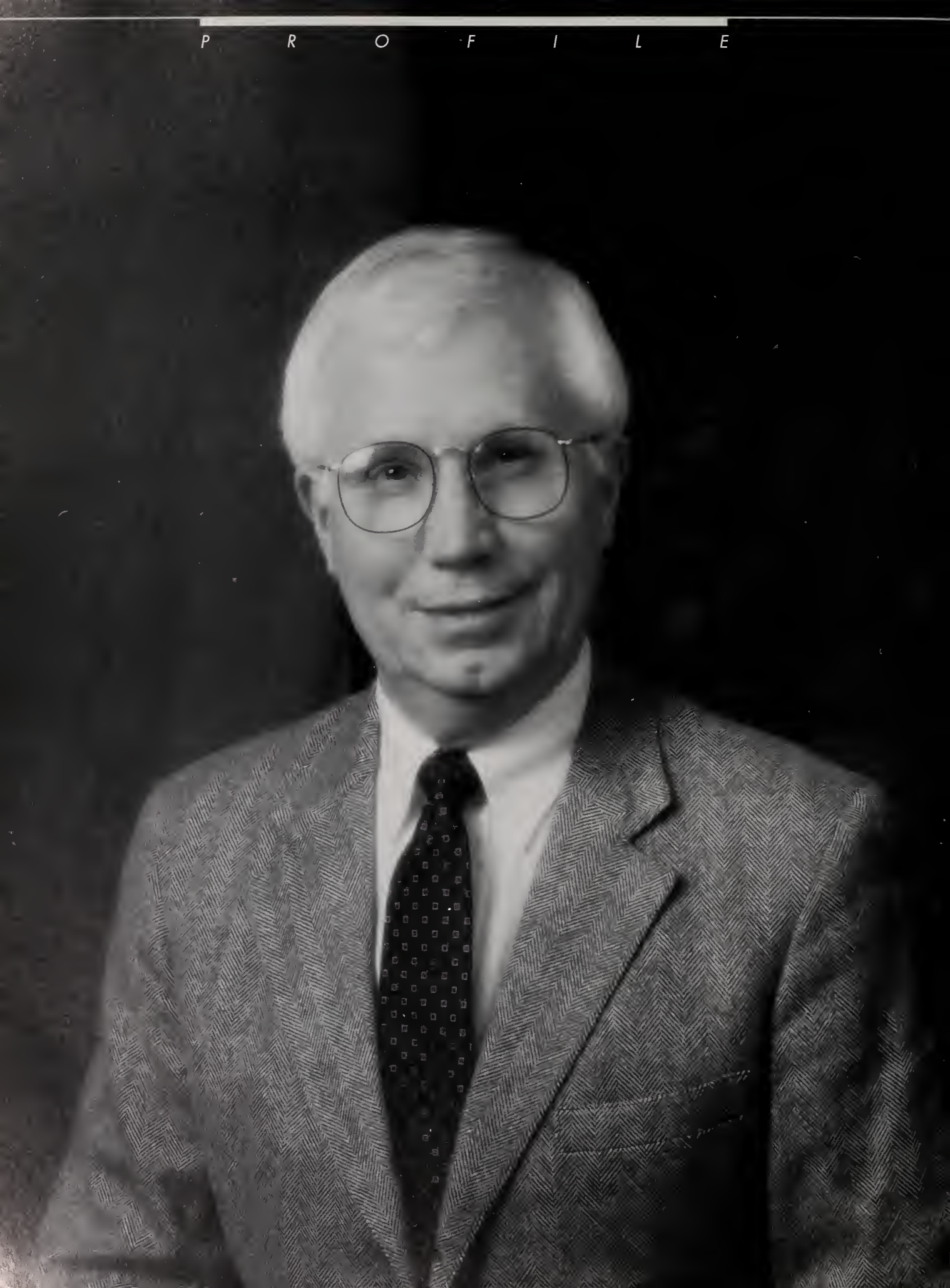
if they had students) suggests that the sample of respondents was similar to the entire sample of 281. This finding lends credibility to our conclusions that the respondent sample was representative of the CBF. The results from this study are drawn from only one institution's cadre of CBF, and therefore, results may not be generalizable to other institutions. However, the study examined an issue that is not the outcome of a program-specific initiative that might be influenced by institution-specific factors. Other institutions may find it of value to conduct a similar assessment of their CBF use of computer skills and opinion of whether students should learn these skills as part of institutional academic computing planning. One source of error accounting for a failure to detect any differences by CBF age may be because two CBF respondents were placed in the 40-44 age quartile to satisfy quartile criteria.

The conclusions drawn from this study further emphasize the need for students to acquire/refine computer skills in the medical school curriculum. The use of these skills should be integrated throughout the curriculum. Academic medical centers involving community-based faculty in student educational experiences need to provide these faculty ongoing support in the form of faculty development in order to best enhance students' learning and computing experience in the community setting.

REFERENCES

1. Harden RM, Smyth JJ. Computer-based study guides II: Educational components and advantages. *Med Teach.* 1994; 16:315-321.
2. Rosse C. The potential of computerized representations of anatomy in the training of health care providers. *Acad Med.* 1995;70:499-505.
3. Friedman RB. Top ten reasons the World Wide Web may fail to change medical education. *Acad Med.* 1996;71:979-981.
4. Lapeyre AC. The World Wide Web is already changing medical education. *Acad Med.* 1997;72:563.
5. Osheroff JA, ed. *Computers in Clinical Practice.* Philadelphia, PA: American College of Physicians, 1995, xi-xiii.
6. Debehnke DJ, Valley VT. Assessment of the current computer literacy and future computer needs of emergency medicine residents and faculty. *Am J Emerg Med.* 1993;11:371-373.
7. Vincent C, Scheeweiss R. How family physicians choose an office computer system. *J Am Board Fam Pract.* 1992;5:275-280.
8. Jones KM, Hunter TB, Boren WL. Computer use and education in radiology programs. *Invest Radiol.* 1990;25:596-598.
9. Chodorow S. Educators must take the electronic revolution seriously. *Acad Med.* 1996;71:221-226.

P R O F I L E



Donald R. Stephens, MD KMA President 1998-99

A rural physician he always wanted to be—and a rural physician he is. Donald R. Stephens, MD, Small Town, USA—and proud of it!

This highly respected physician has indeed remained true to his rural roots, and to the Association that provided a pathway to fulfilling his dream of a medical career. A scholarship recipient of the KMA Rural Kentucky Medical Scholarship Fund, Don Stephens is one of the best investments that Fund ever made. He has gone far above and beyond his original commitment to rural practice. That is if one considers dedicated service from the second year of medical practice all the way to the top—being inaugurated the 148th President of the Kentucky Medical Association—while continuously maintaining a rural practice, "above and beyond."

Dr Stephens' commitment to the RKMSF runs so deep that he has served as Chair of the Fund for many years. Though his list of KMA achievements is impressive, some of his greatest contributions and personal rewards have come through involvement in the Fund. He views this pragmatically. "We have four other doctors in my community who received a Rural Scholarship, and they continue to practice there. As a result, we're no longer a critical or needy area, from the standpoint of primary care physicians. The Scholarship Fund has a big investment here in the state and has put a lot of money in education. Those of us who received scholarships owe this state something. This is my way of paying back for what they did for me."

This self-proclaimed "country doc" is undeniably that—if being caring, compassionate, always available, advocating good old-fashioned civility, and never turning a patient away because they cannot pay, fits the profile of a "country doc." In his soft-spoken, reluctant style, Dr Stephens says, "I never refuse patients who don't have money. I like being of service, of contributing when there is a real need. And I'm not alone in my philanthropy—most physicians quietly donate 5-10% of their practice time to treating indigent nonpaying patients."

Though he has chosen to practice in a small town, there is no doubt that when it comes to savvy business acumen, organization, strategic planning, and keeping ones finger on the pulse of medicine, President Stephens can hold his own in any urban setting in Kentucky. He continues to be an outstanding leader with his capabilities, accomplishments, and unflagging devotion to organized medicine. He possesses strong personal drive, well-defined goals, and the desire to serve the medical community.

The Presidency

"The President should be one of consistent and long-time participation in the organization; one who always promotes KMA policies which he or she has shared in formulating for many years; and particularly one who remains an informant to membership on the changes in the practice of medicine affecting Kentucky as well as our country," is his straightforward perspective on the presidency. Dr Stephens is a team player—ego plays no part. He will view his year as President a success "if I can *share* an important role in the unification of physicians in an effort to ensure their survival and a return to the healthy practice of medicine throughout Kentucky."

He will emphasize three themes during his tenure:
— A strong unified group of physicians
— Strategic planning
— Information through communication

Unification

In expressing his wish for the development of a strong unified group of physicians, Dr Stephens warned that political factions make it difficult for physicians to act as a unified force and stressed that physicians must learn to work together in joint efforts, which may represent the last hope of controlling their destinies.

"The organizations that remain powerful and effective are those with leaders and members who are willing to work hard and to dedicate their time and effort," he stated. "Unfortunately, some of our best and brightest are not contributing. The problem is this healthcare milieu with people who have a lot of different interests to serve. We must all strive to acquire an overview and act on behalf of our patients and the organization—by setting goals and standards that are attractive to members as well as nonmembers; by contacting our colleagues who are not members and convincing them of the importance of joining hands with organized medicine as it faces, perhaps, its toughest times; by working hand in hand to preserve the good aspects of our system while helping to shape the changes.

Perseverance is abetted by encouragement, and the Kentucky Medical Association is an encourager. We may not be perfect, but to that end we must constantly encourage and empower one another. I don't have any false sense about it all happening in a year's time, but we must work on it."

Dr Stephens wishes to emphasize the influence a single physician can exert, a thought that runs counter to current wisdom relegating solo practitioners and small groups to history. He wishes to emphasize "change" and not elimination. "Each individual physician will continue to exert leverage by staying active and involved," he says.

Strategic Planning

Acutely conscious that the Association's greatest foe is contentment, its greatest danger is neglect, and its greatest enemy is apathy, then President Ken Peters with strong support from President-Elect Stephens spearheaded a June 1998 strategic planning conference, which proved successful in providing a roadmap and some 5 years of direction for the Association in traversing the future.

"Ken Peters and I have been friends for years. We were medical school classmates. We think a lot alike and have through the years. He's urban, I'm rural, and we complement each other with our ideas. We share a common goal that this Association serve every physician, regardless of specialty or practice location. Ken and I are both primary care physicians, but we don't like to be called 'gatekeepers,' just call us physicians. Government intervention put us in the gatekeeper position. The specialties have heard enough about primary care docs. They want to get on with business, and so do we." He continued, "We must travel a pathway together, and if we have problems, solve them in that pathway and not deviate out. In preparing to meet the challenges of the future, Ken and I knew we must have a unified vision for the future. Thus, the development of Ken's dream of a long-range strategic planning conference.

"For the conference, we convened a broad demographic range of physicians in the quiet, get-away setting of Shakertown. We brainstormed and we set goals. This meeting and the information gleaned from a survey sent to every physician in the state resulted in 10 masterpiece plans the Association will be promoting for the next 5 to 7 years. For the organization to survive, we must have a strategic plan for the future—we can't just focus on today's problems.

"I do want to reiterate that the KMA will continue its efforts to espouse doctor/patient relationships unfettered by government and other third party payors. We will continue to espouse freedom of choice—for the patient to choose a physician and for the doctor to choose a plan or plans in which he or she wishes to participate.

"We are committed to carrying out this plan in the coming years."

Information Through Communication

"It is imperative that the Kentucky Medical Association be a center of information for *all* physicians throughout the state. Communication in our diverse and threatened environment is crucial. Governmental interference, different plans, pay programs, contracts, HMOs, PPOs, PHOs, and those yet to join the acronymic pool, require knowledgeable physicians. I think KMA can provide this knowledge.

"About 10 to 15% of physicians in the state seem to have the misconception that KMA provides little assistance to them as private practicing physicians. They're so uninformed—not misinformed—uninformed, because they don't open their minds to what is really occurring that affects them. It's important to communicate to them that we share common challenges and goals, that they need us as much as we need them, and more so.

"Of primary concern is a need to communicate with our patients. They are our allies, and they are rallying behind us. They are unhappy, and they realize doctors are not to blame, that the blame lies with those factions turning medicine into big business. They want to return to the traditional patient/physician relationship, they do not want to be assigned a physician, they want what we want—freedom of choice." He spoke with conviction, "You know, in the end it is still the doctor and the patient. We must stand united with our patients against the forces of sickness, and anyone or anything that stands between us in our battle of disease and cure, sickness and health."

History in KMA

Following service for 23 years as 9th District KMA Delegate, several years as an Alternate Trustee, three terms as Trustee, Board Chair for two terms, *decades* of committee involvement, Vice President, President-Elect, and now facing a demanding year as President, Don Stephens has earned a reputation for pushing on in organized medicine when many others would relax and retire. His sprightly walk, slim physique, and youthful grin belie the recent celebration of his 65th birthday, but he has no plans to slow down.

"I'm not a person who serves as President and then disappears," he says candidly. "I enjoy being active and serving the Association. You know, we need senior citizens just like we need the young docs. During KMA meetings, there's a vast array of knowledge sitting at the table for the younger doctors to absorb and use. We senior docs have experienced the good and the bad. Many of our younger colleagues have not yet experienced the good—and they certainly aren't experiencing it now! Those who can learn and adapt will survive the plethora of changes in medical practice and be better physicians. That's one of the motivating forces for our hard work and in depth planning—to give them an opportunity to practice *good medicine*, free of governmental or third party interference."



Dr Stephens and his wife Sonia were surrounded by all five of their children on this very special day. Pictured left to right are daughter Jane, daughter-in-law Laura, son Doug, the Stephens, son Dennis, daughter Susan and her husband Michael Grieff. The Stephens' eldest son Don Jr, an attorney, was present for the inauguration ceremony, but a business commitment required that he leave prior to the photo session.

KMA Membership

Once Don Stephens has committed to any project, he is in, body and soul; and if succeeding requires the art of gentle, or not so gentle, persuasion, so be it. "Membership is struggling for economic survival and clinical autonomy. If we do not satisfy those basic needs, as an organization we will no longer be relevant, and as an organization we will not survive. We physicians can really reinforce each other against this huge, serious problem we are facing," he said. "We've got to find the answers. I know that more and more physicians will see the advantages of belonging to KMA and the AMA. We need younger physicians to be involved at the leadership level. The sooner they become involved, the more active they will be, and the longer the Association can benefit from their participation at the leadership level. It's a big job. But we fail if we don't get the word out and generate interest in the only game in town—power through unification in organized medicine. We have the power to control our destinies if we pull together. What a force we can be!"

Image of a Physician

President Stephens is concerned that the respect and prestige of physicians is changing. "I'm very outspoken on my ideas of what a doctor should be and how we should conduct ourselves in our community, in community politics, and in medical politics. To garner respect, we should conduct ourselves with civility, and our appearance should project professionalism. How we conduct ourselves individually in our practices, as parents, as spouses, in community involvement is so vital to the image of physicians as a whole."

One whose record of community involvement reads like a model of what organized medicine has long espoused can comfortably ask convicting questions. "Are we involved in our community? Does the community see us in our office and nowhere else? Are we contributing to and mentoring others?"

Cynthiana folks do know "Doc Stephens" outside his medical practice. He has served on the Harrison County School Board for 21 years and as an Elder in the Presbyterian Church for 20, and he plans to continue that service. Through the years, he has served on too many local committees to enumerate here. It's difficult for him to say no if it involves the betterment of the community. He's always enjoyed interacting with people, and he's always enjoyed making a change—making a difference.

Personal Background

Don Stephens envisions a successful organization as one in which members are committed, dedicated, involved—with a measure of hard work and sacrifice thrown in. He has not arrived as the leader of the Kentucky Medical Association on a free pass. He has achieved this status with natural endowments, hard work, and an extraordinary ability to remain focused, as evidenced by decades of involvement. His background ensures his work ethic.

The Early Years

A native of Williamsburg in Whitley County, Dr Stephens was born into a loving, hard-working, supportive family, but his parents never encouraged his

becoming a physician. "They felt it would take too long, be too hard. They were high school graduates, and they made a respectable living. My father was a coal miner and my mother a factory worker. But I had a mentor, encourager, and dear friend in my family doctor, L. X. Brown. Through the years we developed a close relationship, and knowing my love for medicine, he took me under his wing and was a major encouragement." Dr Stephens laughed as he admitted, "Dr Brown had me fooled, though. I would look at the hours posted on his door—10 to 12, and 2 to 4—and think '4 hours of work a day and all that free time. That's for me!' Then I began to realize that I was seeing him out at night, that he delivered me, at home, at night! But I still wanted to be a physician.

"When my parents became convinced I was going to pursue my dream, they agreed and gave me financial assistance all the way through school. I'm probably one of few who graduated owing only my Rural Medical Scholarship Fund." Dr Stephens' expression softened as he reminisced, "It is somewhat sentimental for me to recall that my mother worked until I graduated from medical school, then she quit. She had sacrificially worked to help me. It was rewarding to my parents that four of their five children attended college. We all educated ourselves through hard work, and with their help. Father lived to be 85, mother 89, and we were richly blessed by their sacrifices."

Education

Upon graduation from small, rural schools, Dr Stephens attended Cumberland College, at that time a two-year Baptist college. He then transferred to the University of Kentucky and in 1956 completed an undergraduate degree in chemistry. He earned his medical degree from the University of Louisville in 1960. A one-year rotating internship was completed at St. Elizabeth Hospital in Dayton, Ohio, in June of 1961. In July, he began practice in Cynthiana. Six years later this practice was interrupted to serve his country in Vietnam.

"I returned to Cynthiana in 1969 and have been in family practice since that time. I've enjoyed a rewarding practice. Before I gave up obstetrics seven years ago, I delivered 2,356 babies, did family practice surgery, did about everything my first 25 years of practice, then I began cutting back."

Family Life

Dr Stephens and Sonia, his wife of almost 40 years, have five children, all of whom attended different colleges and took different career paths, and he is pleased to note that all have been successful. His seven grandchildren, five boys and two girls ages 13 months to 9 years, are "wonderful and provide so much enjoyment for Sonia and me."

He met his wife in 1958 when she was working as a registered nurse in Madison, Indiana. They married in 1959. Together the Stephens enjoy "relaxing on my day off—Thursday is Sonia's day—we go to movies, to the city to shop, visit our children," he says. "I play a little golf, and we both enjoy watching football and basketball. Sonia is a native of Indiana, but I converted her to a "Big Blue" fan. Being a graduate of both UK and U of L, I run blue and red, except when they play each other, then I'm a little more blue."

Presidential Legacy

"As a good servant who dedicated his time and energy to the medical community, to the Kentucky Medical Association, and primarily to achieving freedom of the practice of medicine with patients' private rights to choose their physician," simply stated, is how "country doc" Don Stephens wants to be recorded in the annals of the Kentucky Medical Association.

Kentucky's medical community, and by extension its citizenry at large, is indeed fortunate to have the services of Don Stephens' talents and energy. His knowledge of the House's procedures and policies equips him to promote the continuing growth, service, and focus of the KMA and to articulate its position and aims not only to its members, but also to all the citizens of the Commonwealth. The mantle of outstanding leadership indeed falls on sturdy shoulders.

—Sue Tharp
Managing Editor

Faithful Stewards . . . A Reflection

While it is perhaps cliché to see the fall as a time for reflection and reassessment, I have found myself this autumn, for many reasons, thinking frequently about our profession, its past and its future. In the last year, many of the physicians who formed the course of medicine as I have known it or who shaped my image of what it meant to be a physician have retired. The organizational structures within which we practice are alien to those I knew as I began my medical career just 15 years ago. The complexity of our relationships with our patients, our colleagues, and our community increases as rapidly as the sophistication and efficacy of the technologies we employ to serve them. Many physicians ruminate about the value of being a physician and question whether they would choose this vocation again if given the choice. In the midst of this change, with all of its discussion of policy, politics, providers, and consumers, I have found myself most often remembering the people who have been such an integral part of the snapshot of medicine I have seen.

"In the last year, many of the physicians who formed the course of medicine as I have known it or who shaped my image of what it meant to be a physician have retired . . .
. . . Don Kmetz
. . . Al Thompson
. . . Milton Miller
. . . Will Ward
. . . and, my father."

About the time I began medical school, Dr Don Kmetz became Dean of the School of Medicine at the University of Louisville. Retiring this year, he was a tireless advocate for his school and its mission to the community, the profession, and, particularly, the next generation of physicians. Dr Al Thompson was my program director in Internal Medicine at the University of Louisville and later Associate Dean. As Al retires this year, I remember all the more clearly his reminder to me that we all owe a great debt to the people and institutions that help form us as physicians and people, no matter how strained and complex those relationships may become. Dr Milton Miller (whose elegant editorials frequently graced this page) and Dr Will Ward, two of my partners in practice, retire this year. They have been palpable examples of a physician's ability to be a compassionate practitioner, conscientious citizen, and humane thinker. They were also a lot of fun to work with.

Most of all, though, I have thought about my father. I wonder what it will be like to go to the hospital or office or conference room knowing that he has retired. There has been no part of my medical life that was not in large part influenced and enhanced by him. From sitting in doctors' lounges and nurses' stations as a kid during his rounds, to applying for and surviving medical school, to becoming partners in practice, he has provided the gentle guidance and stalwart example we all crave in a mentor. The palpable vacancy his retirement will leave in my daily work is enormous, but the knowledge that he leaves his life's work fulfilled, content, and with the deep gratitude of his patients and friends is a great comfort.

"Most of all . . . I have thought about my father . . . The palpable vacancy his retirement will leave in my daily work is enormous, but the knowledge that he leaves his life's work fulfilled, content, and with deep gratitude of his patients and friends is a great comfort."

As I consider the contributions of these doctors to the world of medicine that I have known, I cannot but believe that all of us share a similar legacy bequeathed from those that taught and inspired us. Similarly, as I wonder who will take their place and transmit this heritage to the succeeding generations of physicians, I see many who have already taken up the mantle and many who have the gifts to do so when called upon. In the end, I come to understand, through the example of the doctors who have willed the care and nurturing of this profession to us, that medicine, our profession, is ultimately about the people who comprise it: the doctors and the patients. We owe it to them and ourselves to be faithful stewards of the gift we live each day.

Daniel W. Varga, MD



Nearly half of all heart attack victims are born under this sign.

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American Heart Association

This space provided as a public service.



Jan Crase

Look in the Mirror

Look in the mirror. What do you see? As a physician, you will probably see most of the following. Someone who—is well educated and well trained in medicine.

- has made great personal sacrifices to become a physician
- works very hard and long hours
- cares about patients
- contributes to the community
- feels frustrated about what is happening to the medical profession

This mirror, no doubt, reflects the brightest and best of our society; however, this last reflection in the mirror is cause for concern. What is the source of this? Are you in control of your workplace and in control of your relationship with the patient, or do you feel out of control and work at the mercy or the whim of others less knowledgeable than you? If those "Others" in control of your life are magnanimous and generous, then all may be well; however, government and big business are not noted for being magnanimous and generous. Both are known for lots of paperwork and inefficiencies, and in the case of big business their primary interest is the bottom line—their bottom line, not yours.

How did physicians lose control of their own destiny? Were physicians a part of the decision making to let government and big business determine how medicine is to be practiced and determine the fees to be paid, or did they just continue to work trying to "get through the day" and let someone else make all those decisions about the profession, the greatest profession in the world? Who made those decisions anyway?

Politicians make the laws and the laws determine the playing field of medicine both now and in the future. Who influences the politicians? The choice every physician and every spouse makes is whether to be a participant in the political process or become a victim. Unfortunately, there is no category of spectator. PLAYER OR VICTIM, THE CHOICE IS YOURS. Most physicians are reluctant to be in the political arena; however, we live in a democracy that is supposed to be government **of** the people, **for** the people, and **by** the people. Those who participate call the shots. It's a good system, and I doubt that you and I could do a better job than Thomas Jefferson and the framers of the Constitution; however, **democracy only works if people participate;** therefore, each of us has a responsibility whether we like it or not. **Responsibilities are inseparable from privileges.** If we don't accept our responsibilities, then we are abdicating our rights and our privileges to others who may not share our philosophies. Lawyers have always been involved in the political system, actors and professional athletes are now involved. Do these groups represent your best interest and your patients' best interest? This system needs the influence of its brightest and best.

Look in the mirror, do you see the boulders in the pathway ahead which must be avoided, or are you plowing on at full speed ahead? Perhaps the day is past when good doctors can "just do their job" and all will be well. *Physician heal thyself* may be more appropriate now than ever before. Our leaders must lead responsibly and the physician

family must be willing to support such leadership. The Alliance has, and always will, find ways to help.

Look in the mirror, are you **registered to vote?** The next election will be in November. If you are not registered, you cannot vote. If you do not vote, you have chosen to become a victim of the political system. If 100% of the physicians and spouses voted in every election, it would be amazing the political clout medicine would have because all the politicians would seek their vote and want to be aware of the needs of the profession.

Look in the mirror, do you **stay informed about medical issues?** The KMA legislative bulletins are excellent, requiring only about 5 minutes to read. Both the AMA and KMA do a fine job of informing its membership; however, this information is of no value if it is not read. Have your home address put on the mailing list of both these organizations so both you and your spouse can read the bulletins and discuss.

Look in the mirror, do you **know your legislators?** They are people like you and me and they tend to listen to and value the opinion of people they know and respect. Break bread with them, have a reception for them. You need that personal relationship to be effective. It has been said that politics is a contact sport, and that is indeed true. The persons in contact with their legislators are more likely to have some influence with them.

Look in the mirror, do you **let your legislators know your opinions?** If so, always, ALWAYS, be respectful. Attacking or blasting or criticizing the person accomplishes nothing. Stick with the issues. Legislators want light, not heat. Help enlighten them and do it precisely, and concisely, always reflecting genuine concern for patients. Whatever you do, don't make it a pity party. They just don't feel sorry for those "rich doctors." Call, write, or fax whether you are *for* or *against* a bill. Believe me, they pay much attention to constituents who bother to correspond or communicate with them. Your call or letter *can* make a difference.

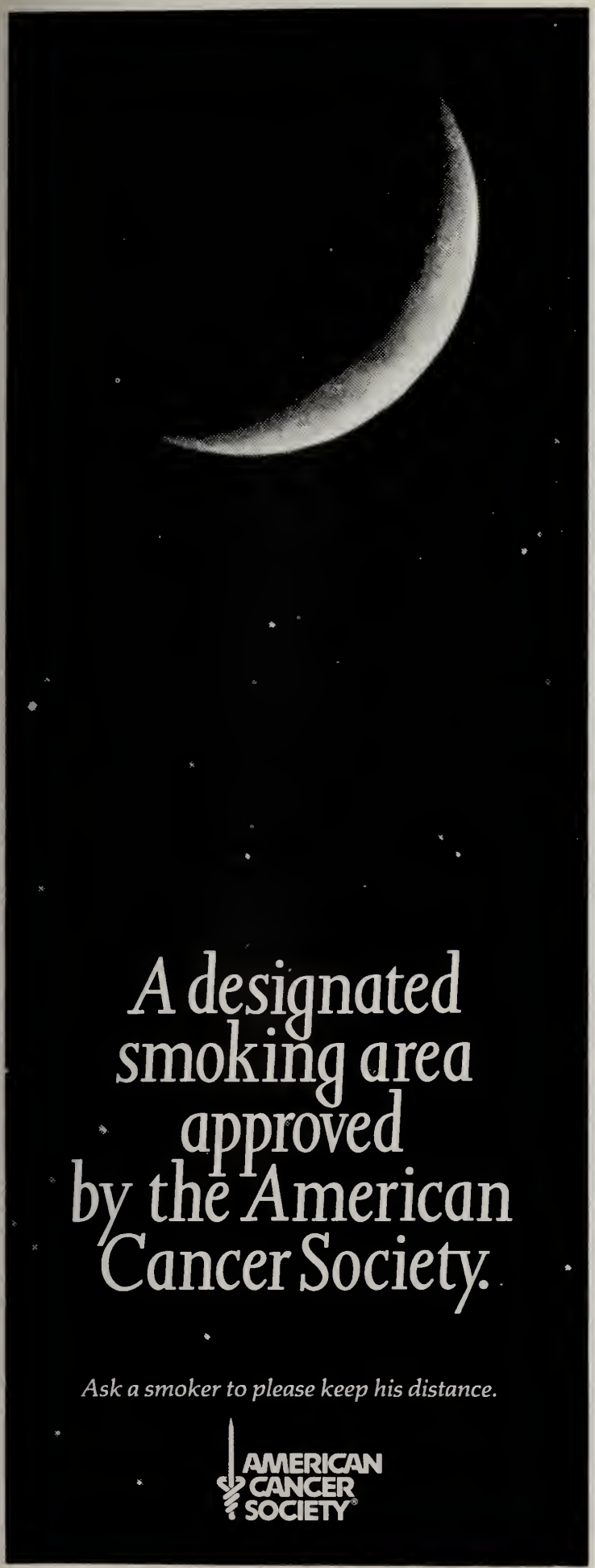
Look in the mirror, do you **support candidates?** If 100% of the physicians donated $200 per year to political campaigns, they would probably be the most influential people in the political arena.

Apathy does not work. It has been tried and failed. Is now the time to take control of the future of medicine?

Look in the mirror, do you see political involvement in your future or that of your spouse? Does your medical family choose to be a participant or do you choose to be a victim? The future health of your patients, your profession, your children, your grandchildren and *you* depend upon your decision.

Look in the mirror, you'll find the answers there.

Jan Crase
KMAA President



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August Board Meeting



Studying the agenda were, left to right, President C. Kenneth Peters, MD, Board Chair J. Gregory Cooper, MD, and Executive Vice President William T. Applegate.

The KMA Board of Trustees met on August 5-6, 1998, at the KMA Headquarters Office in Louisville.

C. Kenneth Peters, MD, President, reported on the strategic planning meeting held in Shakertown last May and noted that all participants received the report from the session.

The Board members heard routine reports from William P. VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Chair, KEMPAC Board of Directors; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner for Public Health; Mrs Jan Crase, Alliance President; and Preston P. Nunnelley, MD, Kentucky Board of Medical Licensure.

Donald C. Barton, MD, Senior Delegate to the AMA, reported that Bruce A. Scott, MD, was elected to the young physicians slot on the AMA Board of Trustees; Ardis D. Hoven, MD, won a seat on the Council on Medical Service; and William B. Monnig, MD, was reelected as Secretary of the Governing Council of the Organized Medical Staff Section.

The new Dean of the University of Louisville School of Medicine, Joel A. Kaplan, MD, was introduced to Board members. The Board voted to include a $10 voluntary assessment for the Legal Trust Fund with the 1999 dues billing.

Appointments were made to the KEMPAC Board of Directors and a Judicial Council nominee was approved. The Board approved nominees for the Kentucky Board of Medical Licensure, Drug Management Review Board, Kentucky EMS Council, Kentucky ACTION, and the AdminiStar Medicare Advisory Committee.

The Board heard additional reports from the Committees on State and National Legislative Activities, Committee on Medicaid Managed Care, Committee on Community and Rural Health, Ad Hoc Committee on Alternative and Unconventional Medicine, and the Public Education Committee.

An update was given on the Annual Meeting, and action was taken on 40 committee reports.

The next meeting of the Board was scheduled for Sunday, September 20, 1998, during the KMA Annual Meeting.













Clockwise from top left: President-Elect Donald R. Stephens, MD; 13th District Trustee Kenneth R. Hauswald, MD, 2nd District Trustee Donald R. Neel, MD, and Vice President Harry W. Carloss, MD; AMA Alternate Delegate Baretta R. Casey, MD, and Vice Speaker Thomas K. Slabaugh, MD; Dean of the Pikeville School of Osteopathy John Strosnider, DO; 6th District Trustee John T. Burch, MD; Secretary-Treasurer William P. VonderHaar, MD.

PEOPLE

Mary Lloyd Ireland, MD, an orthopedic surgeon for Kentucky Sports Medicine Clinic and team physician for Eastern Kentucky University, has been named recipient of the 1998 President's Challenge Award by the National Athletic Trainers' Association for her dedication to sports medicine and cooperation with certified athletic trainers.

UPDATES

Federal Government Offers Free Computer Based Training on Medicare

The Federal government has received a grant to conduct training sessions around the country on various issues concerning Medicare. There are free computer-based training sessions the government has developed which may be obtained on-line at www.medicaretraining.com. Once you log on, go to the section entitled "computer based training." There are sessions on the following subjects:

- Fraud & Abuse
- ICD-9-CM Diagnosis Coding
- Front Office Management
- Introduction to the World of Medicine
- CPT Procedure Coding for Beginners

Sessions must be downloaded which can take several minutes depending on the type of computer used. These sessions are informational in nature and not approved for CME credit.

Recognition of DNR Orders by EMS Personnel

Kentucky law requires emergency medical responders to honor Do Not Resuscitate orders *only on a standard form* approved by the Board of Medical Licensure and the Cabinet for Health Services. EMS personnel will not acknowledge any other directives. These orders apply only in the prehospital setting such as in patients' homes, in nursing homes, or during transport to and from a health care facility.

Once summoned, EMS personnel are required and trained to respond aggressively. Unless the specified DNR form is present or available, EMS personnel must resuscitate. Resuscitation efforts *that must be performed* include external chest compressions, intubation, defibrillation, administration of cardiac medications, and artificial respiration. If the patient has an EMS DNR order, EMS personnel may still provide other emergency care such as administration of oxygen, suctioning, control of bleeding, administration of analgesics, and comfort care.

EMS DNR forms are readily available from ambulance services, EMS services, and the Board of Medical Licensure. The Kentucky Emergency Medical Services Department advises that properly executed forms be kept close to vulnerable patients. The form is small enough to be worn in a standard size hospital bracelet. Care givers or other persons who are routinely near vulnerable patients should be aware of the existence and location of the forms.

To avoid the obvious difficulties, physicians should work on this issue with vulnerable patients, available family members, and long term care facilities that house their patients.

Zeneca Pharmaceuticals Receives FDA Approval for Zoladex

Zeneca Pharmaceuticals announced that it has received Food and Drug Administration approval to market ZOLADEX® (goserelin acetate implant) in combination with the antiandrogen flutamide prior to and during radiation therapy for the management of early stages of prostate cancer (Stages B_2-C—disease locally confined to the prostate gland). According to Zeneca, this indication makes Zoladex the first and only hormonal treatment in its class (LHRH-A) approved for combination treatment against early stages of prostate cancer. The approval of the supplemental new drug application, which includes both the 3.6mg monthly depot and 10.8mg three-month depot formulations, marks a broadening of the existing indication for the palliative treatment of advanced prostate cancer.

AWARE Foundation

The North American Society for Pediatric and Adolescent Gynecology (NASPAG) has announced the formation of the Adolescent Wellness and Reproductive Education (AWARE) Foundation, dedicated to empowering and motivating adolescents and young women to take charge of their reproductive health.

The Foundation's goal is to educate young women and men, families and health care providers in order to open a dialogue and foster healthy communications. Parents, friends, and teachers will be able to have a more informed impact on adolescents' decisions concerning sex, wellness, and other issues. The AWARE Foundation will help bridge communication gaps between adults and teens by communicating directly with all groups about reproductive wellness.

For further information, contact the AWARE Foundation at 1015 Chestnut St, Suite 1225, Philadelphia, PA 19107-4302 or visit their web site at www.awarefoundation.org.

New Sports Medicine Plan for U of L

U of L has announced a unique partnership with Jewish Hospital and Frazier Rehab Center to provide student-athletes with one of the most comprehensive sports medicine programs in the nation. In addition to extensive pre-season physicals, the arrangement provides for preventive

and rehab services at the two facilities. In addition, Jewish Hospital will manage first-aid stations and provide a mobile trauma unit during games at Papa John's Cardinal Stadium.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Clay

Sharon K Fogleman MD — FP
H C 69 Box 701, Beverly, KY 40913
1982, U of Iowa

Hart

Swaranjit K Chani MD — IM
207 E Main St, Horse Cave, KY 42749
1990, Lady Hardinge Med Col, India

Kenton

Kim-Anh T Vu MD — FP
900 Medical Village Dr, Edgewood, KY 41017
1996, Ohio State U

Lawrence

Gregory L Baker MD — OTO
P O Box 688, Louisa, KY 41230
1978, U of Alberta

McCracken

Elmer Amor Toliver MD — FP
P O Box 9301, Paducah, KY 42002-9301
1986, St Louis U, Philippines

Shelby

Bruce Edward Katz MD — ORS
2033 Midland Trail, Shelbyville, KY 40065
1991, George Washington U

Union

William B Bebout MD — FP
4600 Hwy 60 West, Morganfield, KY 42437
1995, Indiana U

Warren

Jane Catherine Gibson MD — FP
1555 Campbell Lane, Bowling Green, KY 42102-9025
1989, U of Ottawa, Canada

Whitley

Rajendrakumar R Ingle MD — PTH
1460 Falls Hwy, Corbin, KY 40701
1979, Baroda Med Col, India

Nelson F Rodriguez MD — P
100 Jasmine Cir Apt 10, Corbin, KY 40701-1176
1985, U of Santo Tomas, Philippines

DEATHS

Ralph J. Angelucci, MD
Lexington
1911-1998

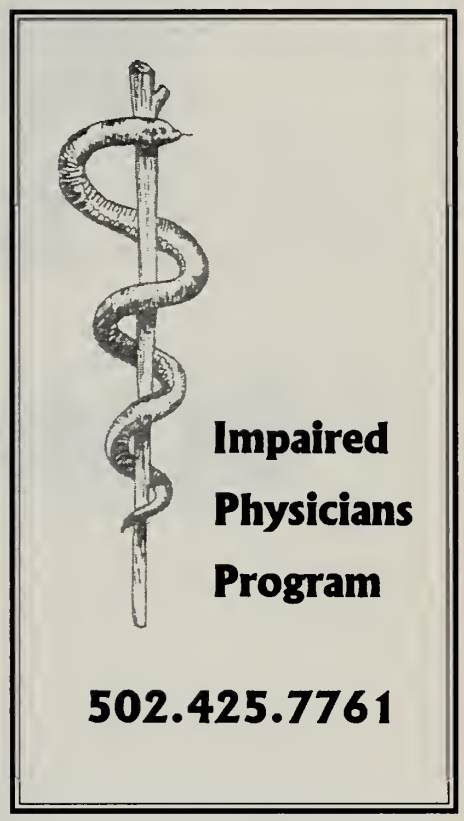
Ralph J. Angelucci, MD, a retired neurosurgeon, died July 18, 1998. A 1938 graduate of Vanderbilt University School of Medicine, Dr Angelucci was a life member of KMA.

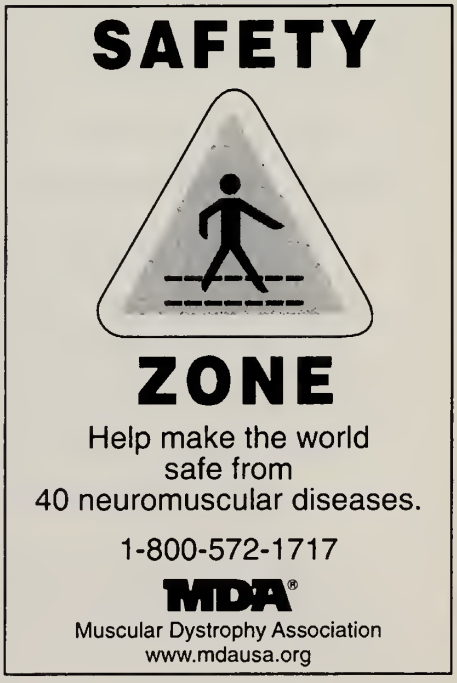
Debra Zukof, MD
Prospect
1957-1998

Debra Zukof, MD, a psychiatrist, died August 1, 1998. Dr Zukof graduated from the University of Louisville School of Medicine in 1985 and was an active member of KMA.

Ralph C. Morris, MD
Louisville
1922-1998

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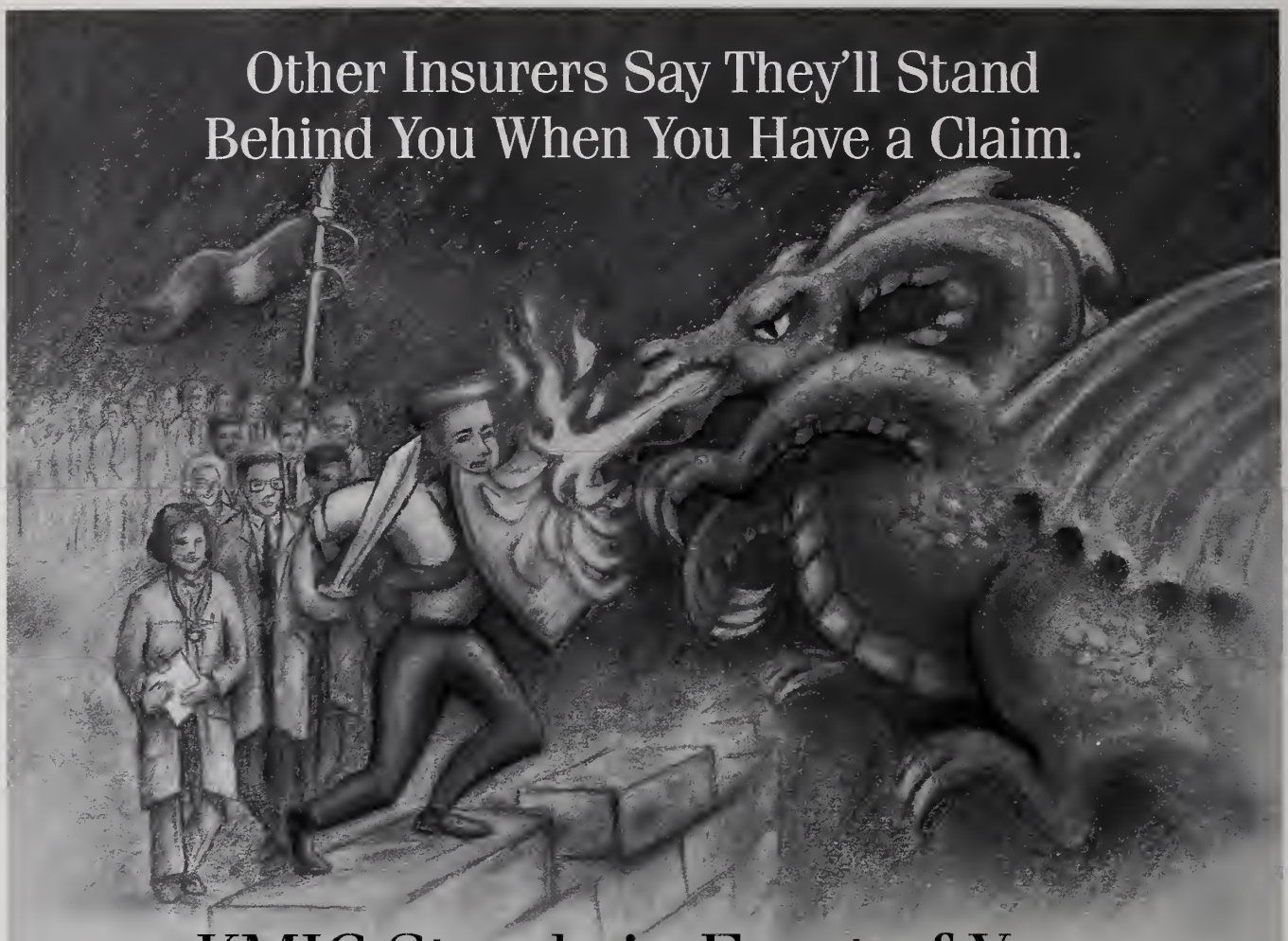
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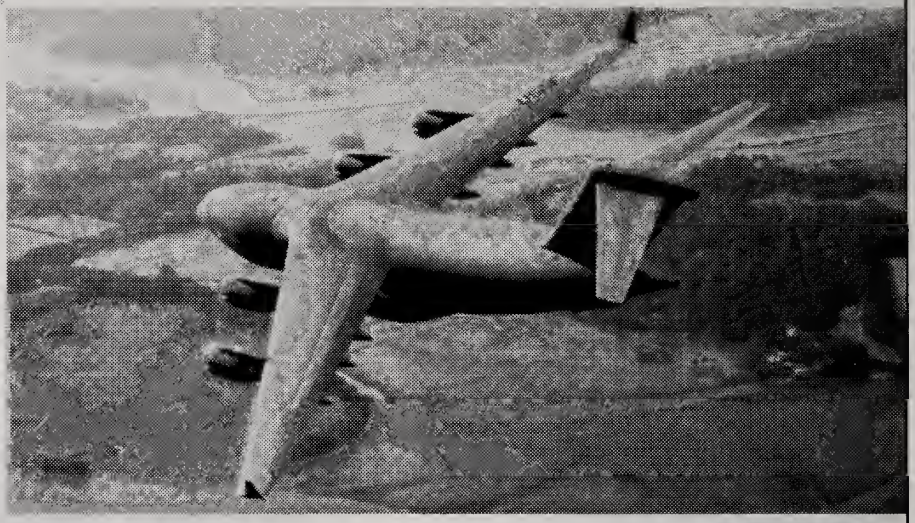
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COVER:
Sexual precacity, evidence of secondory sexuol chorocteristics before the age af 9 yeors in boys and 8 years in girls, is discussed in an article beginning an page 441. This presentatian was designed ta aid in the initiol evoluation and ta focilitote the identification af those children who would benefit from referral ta a pediatric endacrinalagist.

Caver art by Lee Wode of Eminence, Kentucky.

COVER STORY	Puberty: When it Comes too Soon Guidelines for the Evaluation of Sexual Precocity *Pamela A. Clark, MD*	**441**
SCIENTIFIC	Treatment of Cryptococcal Arthritis With Fluconazole Monotherapy *Frank Lee, MD; Pran M. Kar, MD, FACP; George R. Aronoff, MD, FACP*	**449**
SPECIAL ARTICLE	Cigarette Smoking in Kentucky: Smoking-Attributable Mortality and Years of Potential Life Lost *Margaret P. Stapleton, MSPH; Clarkson T. Palmer, MD, MPH*	**451**
MEDICO-LEGAL	Dealing With "Excluded Providers"; Contracts That Can Bring Trouble to Physicians *Patrick T. Padgett*	**457**
EDITORIAL	The Elixir of Hope *A. Evan Overstreet, MD, Editor*	**459**
ASSOCIATION	*Monitoring Medicine*	**437**
	Member-Get-a-Member Campaign	**460**
	Physician's Recognition Awards	**466**
	News	**463**
DEPARTMENTS	President's Page	**435**
	Advertisers' Guide	**470**
	Alliance Page	**461**
	Information for Authors	**447**

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75 Years of Service



Donald R. Stephens, MD

The Kentucky Medical Association Alliance (KMAA) is in its 75th banner year. Most physicians are aware of the Alliance's most visible project, AMA/ERF (recently renamed AMA Foundation), which annually raises money to fund scholarships and student activities for medical schools. But that's just one small example of KMAA works that go on every day on behalf of our patients and the profession. Perhaps no organization has been more progressive, more courageous, and more beneficial to Kentuckians. KMAA labors go largely unnoticed as its leadership and membership proceed about their business "doing good." In practically every edition of the *KMA Journal*, the President of the Alliance reports. Consequently, I thought it might be refreshing to go back and review recent articles and reports and prepare a brief summary:

- "I Can Choose" handbooks distributed to 10,000 Kentucky children, teaching them about conflict resolution
- Posters/bookcovers to over 31,000 students with messages on prevention of HIV/AIDS and sexually transmitted diseases
- "800" hotline numbers provided to report domestic violence
- SAVE, or Stop America's Violence Everywhere, and "Hands are NOT for Hitting" placemats for children on how to treat others in a positive manner
- Health Scholarships
- Medical Scholarships
- 100,000 flyers to Kentucky school teachers and staff on breast cancer awareness
- Growing Healthy, a school program which enhances decision-making skills and improves self-esteem
- SMART, "Students Made Aware Reject Tobacco," which teaches the health and cosmetic effects of tobacco use

The media paints our profession with a "broad brush." Medical students, residents, and young physicians feel especially vulnerable and tell us that their greatest concern is the image portrayed by organized medicine to the public and our patients. Unfortunately, politics dictates that we grapple with a plethora of socio-economic issues, which plague the profession. While the average physician spends most of their

"The work KMAA does every single day on our behalf provides the profession and this Association the opportunity to go about our business of taking care of patients. KMAA's good work accrues to this profession and we need to take notice."

"Perhaps no organization has been more progressive, more courageous, and more beneficial to Kentuckians."

time and resources on patient care and live honorable and fruitful lives, nonetheless, we still feel "besieged" by our critics.

That's where the KMAA enters the picture. The KMAA provides that positive and pro-active public force that strives to make inroads into debilitating diseases and health and safety concerns that exist within society. Whether the KMAA is working on seat belts, child restraints, domestic violence, lowering the BAC of vehicle operators, organizing Ronald McDonald Houses, working with the homeless, increasing the rate of immunization among our children—wherever you turn, they have some worthwhile project underway.

While the KMAA is working on projects to promote health and safety, they stand shoulder to shoulder with the KMA in the legislative and political arena. They have operated a statewide phone bank for many years. In 1998, Jefferson County Medical Society Alliance generated 1000 phone calls to one vitally important, but "wavering," legislator who was "waffling" on KMA's Patient Protection legislation. This is just one example of a statewide project of the KMAA that occurs every Session of the General Assembly.

The purpose of this "overdue" editorial is twofold. We want to re-emphasize and recognize KMAA as a full partner to this profession. The work KMAA does every single day on our behalf provides the profession and this Association the opportunity to go about our business of taking care of patients. KMAA's good work accrues to this profession and we need to take notice. Secondly, urge your spouse to join—dues are inexpensive.

As KMA begins preparing for the 1999 congressional battles over Patient Protection, and as we work toward the 2000 Kentucky General Assembly, the KMAA will be crucial to our success. KMAA member contributions and the integrity the Alliance brings to this profession make us all proud. Return the thanks and make KMAA members proud by supporting their laudable goals to provide assistance and a voice for our youngest and most vulnerable citizens.

Donald R. Stephens, MD
KMA President

NEWS FOR KENTUCKY PHYSICIANS

SEXUAL HARASSMENT

A recent decision by the United States Supreme Court said employers (including physicians) may be held liable for sexual harassment committed by their employees. The court also said, however, that employers can protect themselves from such liability by establishing and implementing an anti-harassment policy.

Federal law prohibits sexual harassment in the workplace and generally applies to a person or entity that regularly employs fifteen or more persons (42 U.S.C. §2000e[b]). Kentucky law also prohibits sexual harassment and applies to persons or entities that employ eight or more persons [KRS 344.030]. These laws make it an unlawful employment practice to discriminate against an individual with respect to hiring, discharging, establishing compensation, terms, and conditions or privileges of employment, because of such individual's sex. Physician employers have a duty to protect employees from sexual harassment by the employer, fellow employees, and even non-employees in the employment setting (ie—patients). Employers also have an affirmative duty to ensure that the workplace is free of sexual harassment.

The courts have defined two general categories of sexual harassment:

"Quid pro quo" sexual harassment occurs if submission to the conduct is an explicit or implicit term or condition of employment, or if submission to or rejection of the conduct is used as a basis for an employment decision affecting the person rejecting or submitting to the conduct. In other words, an employment decision cannot be based on whether the employee submitted to sexual conduct.

"Hostile or offensive environment" sexual harassment occurs if the conduct is used as a basis or effect of substantially interfering with an affected person's work performance or creating an intimidating, hostile or offensive work environment. "Sexually harassing conduct" consists of unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Such conduct may include, but is not limited to, sexual propositions or threats, making sexual gestures, making sexually suggestive or derogatory remarks, slurs or jokes, displays of sexually suggestive pictures or cartoons, and many forms of unwelcome physical touching.

To help physician offices avoid liability for sexual harassment, the KMA has drafted a sample sexual harassment policy that can be tailored to fit a particular practice. This sample policy is set out on the next page.

KMA

Sample Anti-Harassment Policy for Physician Practice

It is the policy of [the Practice] to strive to maintain a working environment for its employees which is free from sexual harassment by supervisors, co-workers or third parties. [The Practice] will not tolerate any act of sexual harassment by any person in violation of this policy.

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Submission to or rejection of any such conduct by an individual is used as a basis for employment decisions; or
3. Such conduct has the result of unreasonably interfering with an individual's work performance or creating an intimidating or offensive working environment.

It is the responsibility of all employees to conduct themselves in ways that ensure that others are able to work in an atmosphere free from sexual harassment. It is the responsibility of all employees to comply with this policy in all respects and at all times. It is the further responsibility of all employees to bring to [the Practice's] attention any evidence of sexual harassment, and to promptly report any act or event that is believed to be a violation of this policy (or that may be a violation of this policy) so that the matter can be investigated as soon as practicable and appropriate action taken.

Anyone having knowledge of alleged harassment is encouraged to report the matter to [the Practice] immediately. Reports, which should be confirmed in writing, are encouraged to be as specific as possible, detailing the nature, date and place of all occurrences, witnesses and any adverse impact. Reported information will be maintained on as confidential a basis as possible, consistent with any legal obligations.

No employee shall be subject to any form of reprisal or retaliation for having made a good faith complaint under this policy.

Any employee who is determined to have violated this policy by engaging in or condoning the sexual harassment of a fellow employee, or retaliating against a fellow employee due to a complaint of sexual harassment, will be subject to immediate discipline up to and including termination of employment.

All allegations of harassment shall be immediately investigated and, if confirmed, will result in appropriate remedial action.

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C O V E R S T O R Y



Puberty: When it Comes too Soon
Guidelines for the Evaluation of Sexual Precocity

Pamela A. Clark, MD

From the Department of Pediatrics, University of Louisville School of Medicine.

Sexual precocity, evidence of secondary sexual characteristics before the age of 9 years in boys and 8 years in girls, can be distressing for families and challenging for primary care physicians. In this article, I discuss the most common causes of early sexual development and provide an algorithm for the initial evaluation of such children. The information presented here is not intended to be a complete guide to the diagnosis of disorders resulting in sexual precocity, but rather is designed to aid in the initial evaluation and facilitate the identification of those children who would benefit from referral to a pediatric endocrinologist.

Little is more concerning to a parent or practitioner than the discovery of signs of pubertal development in a young child. The following discussion is designed to simplify the initial evaluation of a boy below the age of 9 years or a girl below the age of 8 years who presents with evidence of pubertal maturation (by definition, sexual precocity), and to aid in the identification of those children who would benefit from referral to a pediatric endocrinologist. First, a brief review of normal pubertal development is provided, followed by a discussion of the most common causes of sexual precocity, their evaluation, and treatment.

Normal Pubertal Development

In boys, the first sign of central ("true") puberty is an increase in testicular size to at least 4 ml. In the United States this typically occurs around the age of 11.5-12 years. Evidence of virilization in the absence of testicular enlargement generally indicates a peripheral cause of sexual precocity. The adolescent growth spurt is a relatively late event during male puberty, occurring on average around age 14 years (genital Tanner stage 4). In girls, breast budding is usually the first evidence of pubertal maturation, and in the United States occurs around age 10.5-11 years. The appearance of pubic hair before breast development is normally seen in a small proportion of the population, but may also signal pathologic, rather than physiologic, activation of the adrenal glands. Menarche occurs after the adolescent growth spurt, on average 2-2½ years after the appearance of breast buds. It should be noted that there is a wide range of normal for the onset of puberty, from age 9-14 years in boys and 8-13 years in girls. Patterns of development are often familial, and children may follow the pattern of either gender parent.

Patient Reports

Child #1—A 5⅝ year-old female is referred for evaluation of pubic hair and acne present for nearly 6 months. The child's mother also had recently noticed a strong body odor after playing outside, and is concerned that menstrual periods may begin at any time. On physical examination the child's height is at the 75th percentile and weight at the 50th percentile, consistent with previous points on the growth curve. Breast development is Tanner stage 1, pubic hair is Tanner stage 3, and scant axillary hair and acne on the forehead are present, but there is no clitoromegaly. A bone age radiograph is 6 years. A 17-hydroxyprogesterone level is in the normal range and a dehydroepiandrosterone (DHEAS) level is 83 µg/dl (prepubertal range <50 µg/dl).

Absence of breast development indicates that the hypothalamic-pituitary-ovarian axis has not yet been activated and menses are not imminent. Evidence of adrenal androgen action (pubic hair, axillary hair, acne, and body odor) in the setting of normal growth and skeletal maturation, a normal 17-hydroxyprogesterone level, and a modest rise in DHEAS concentration, makes the diagnosis of benign premature adrenarche.

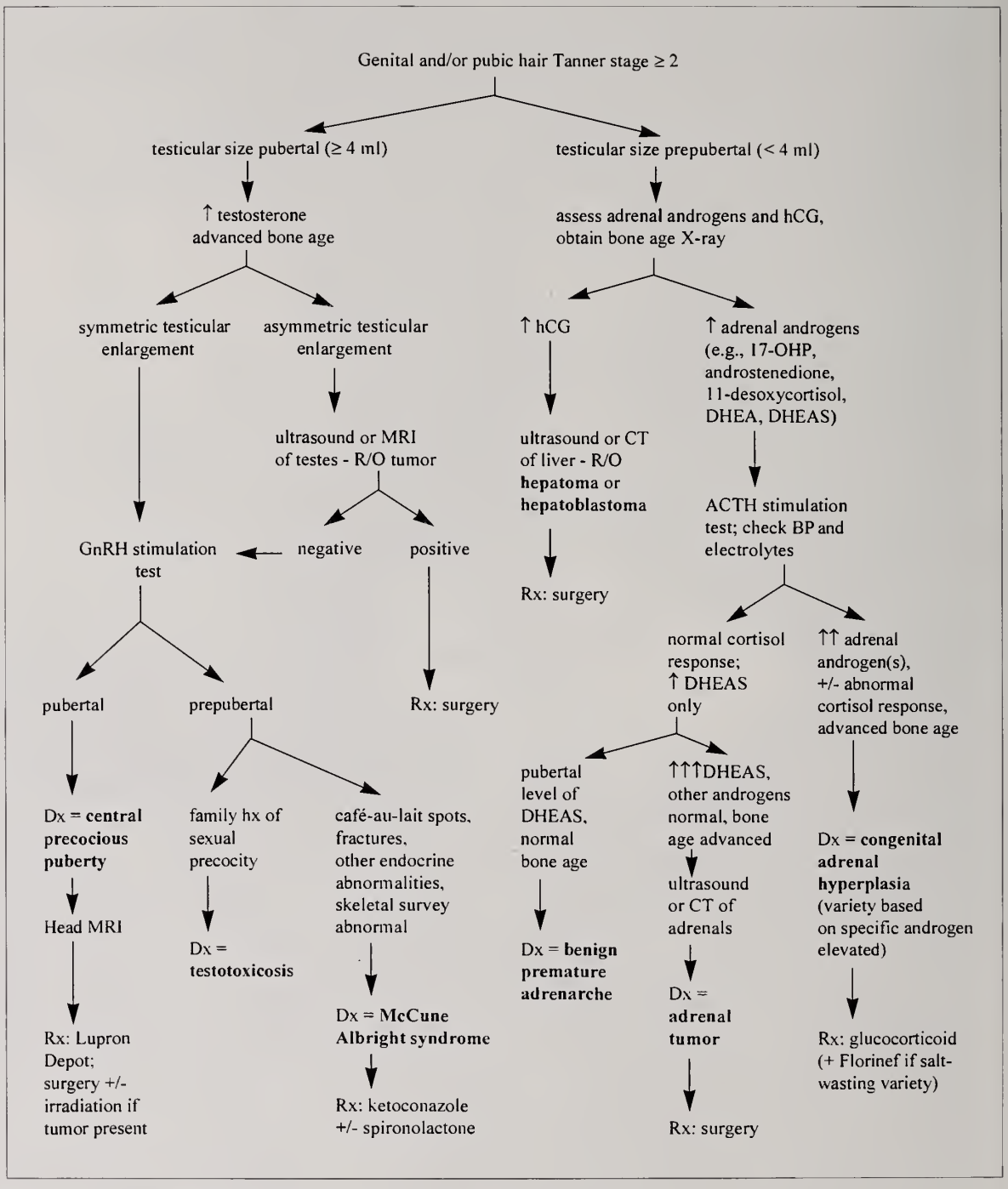


Figure 1 — Simplified Algorithm for the Diagnosis of Sexual Precocity in Boys

Child #2—A 6½ year-old male is noted to have pubic hair and increased phallic size. Physical exam reveals Tanner stage 3 genital and pubic hair development, but testicular volumes of 2 ml bilaterally. Height and weight are at the 90th percentile, although several years ago they had plotted at the 25th percentile. A bone age radiograph is markedly advanced at 12 years.

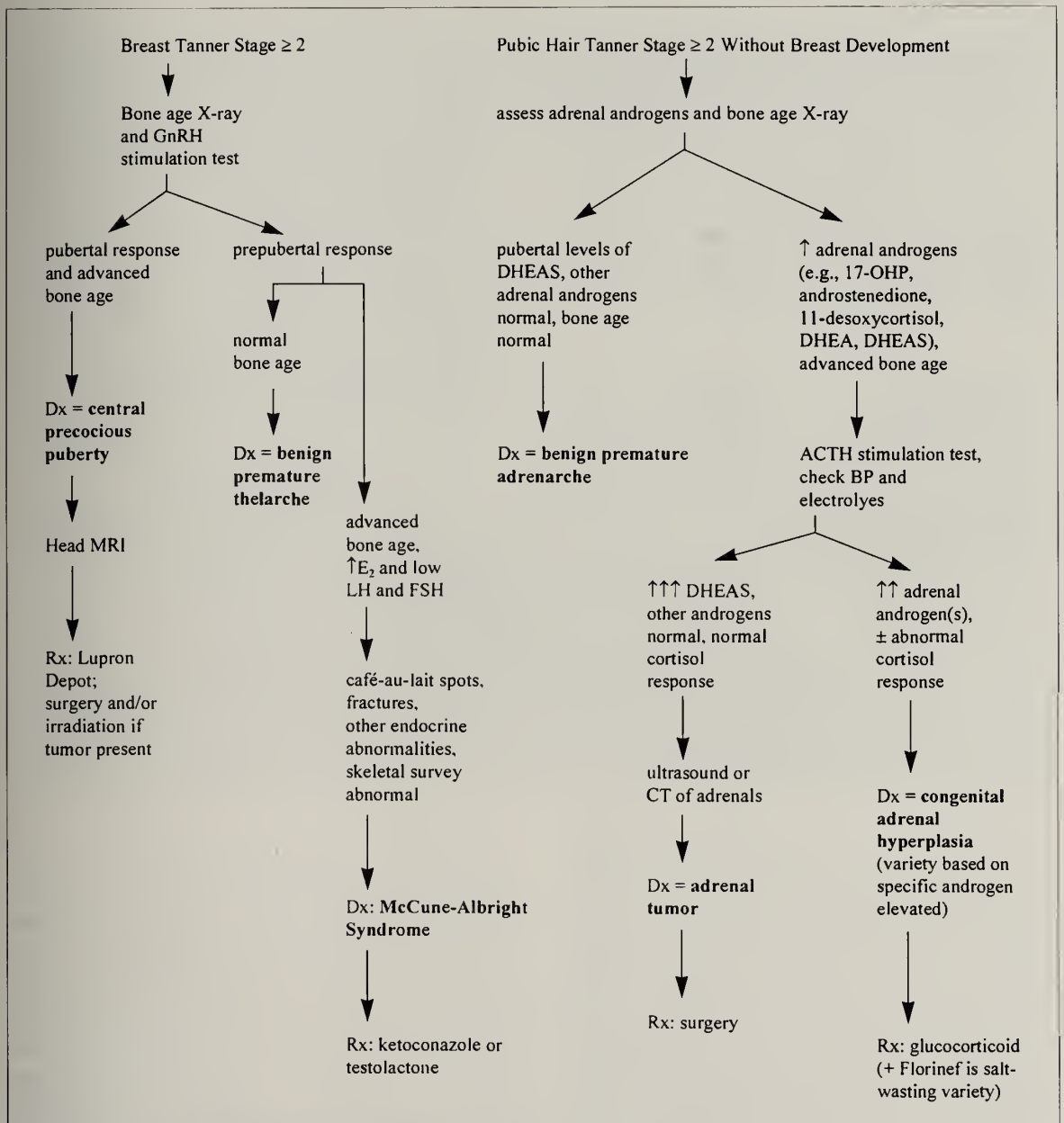


Figure 2 — Simplified Algorithm for the Diagnosis of Sexual Precocity in Girls

Absence of testicular enlargement indicates that an adrenal etiology of androgen production is likely. An elevated 17-hydroxyprogesterone level confirms the diagnosis of congenital adrenal hyperplasia. Although glucocorticoid therapy will slow skeletal maturation and growth to an age appropriate rate, the delay in diagnosis and resultant advancement of the bone age will significantly limit adult stature.

CAUSES OF SEXUAL PRECOCITY

Central Precocious Puberty

Central ("true") precocious puberty is the activation of hypothalamic-pituitary-gonadal axis before age 9 years in boys or 8 years in girls. It is characterized by rapid linear growth and advancement of skeletal maturation, and the appearance of testicular enlargement and increased phallic size in boys or

Table 1. Laboratory Studies in the Evaluation of Sexual Precocity

Hormone	Source	Associated Disorder
Testosterone[1]	Testes, smaller amounts by adrenal	Central precocious puberty Testicular tumors Familial gonadotropin-independent sexual precocity (testostoxicosis) McCune-Albright syndrome
LH, FSH	Pituitary	Central precocious puberty
hCG	Tumor	Hepatoma, hepatoblastoma
DHEA, DHEAS	Adrenal	Premature adrenarche Adrenal tumors CAH[2]: 3β-ol dehydrogenase
17-OH-progesterone	Adrenal	CAH: 21-hydroxylase, 3β-ol dehydrogenase
Androstenedione	Adrenal	CAH: 21-hydroxylase
17-OH-pregneneolone	Adrenal	CAH: 17α-hydroxylase
Deoxycorticosterone	Adrenal	CAH: 11β-hydroxylase, 17α-hydroxylase
11-deoxycortisol	Adrenal	CAH: 11β-hydroxylase

Stimulation Tests

GnRH or Factrel Stimulation Test—Used for the diagnosis of central precocious puberty. Factrel (100 μg) is administered SQ or IV and levels of LH and FSH are obtained at baseline and during the subsequent 20-60 minutes.

ACTH Stimulation Test—Used for the diagnosis of congenital adrenal hyperplasia. Cortrosyn (synthetic ACTH; 250 μg) is administered IM or IV and levels of cortis and adrenal androgens are measured during the subsequent 30-90 minutes.

1. Early in the course of true puberty levels of testosterone are highest in the early morning and wane throughout the day
2. CAH = congenital adrenal hyperplasia

breast development in girls. Although the etiology is idiopathic in nearly 95% of girls, boys have a higher incidence of CNS disturbances as the underlying cause. Early in the course of central precocious puberty, sex steroid hormones and gonadotropins (LH and FSH) may or may not be significantly elevated on random evaluation. A Gonadotropin-releasing hormone (GnRH) stimulation test (also referred to as a Factrel stimulation test) can aid in the diagnosis, because low baseline levels of these hormones rise several fold if the hypothalamic-pituitary-gonadal axis has been activated.

Premature Thelarche

Thelarche is the isolated appearance of breast development in a girl under 8 years of age. It may be unilateral or bilateral and generally the nipple and areola remain pale and infantile in appearance. Unlike central precocious puberty, there is no acceleration of linear growth, no undue advancement of skeletal maturation, and adult stature is normal. In addition, there is no progression of breast development, often some breast regression occurs, and menarche is at an appropriate age.[1] In infants this is thought to result from delayed inhibition of the "minipuberty" of the neonatal period. This must be differentiated from persistent breast tissue from maternal exposure in utero which is common in both genders and may persist up to 2-2½ years. In older girls isolated thelarche may be due to unsustained or intermittent follicular activity which is capable of producing small amounts of estrogen. Breast tissue may persist for long periods after such hormonal stimulation has abated.

Premature Adrenarche

In my experience, the most common referral for sexual precocity is a girl between 4 and 8 years of age with pubic hair development. A common misconception held by parents and physicians is that female puberty is the result of one coordinated process. In actuality, female puberty is comprised of two very separate and distinct components: (1)

activation of the hypothalamic-pituitary-ovarian axis leading to estrogen production, breast development, and menstrual cycles; and (2) production of androgens from the adrenal glands, leading to pubic and axillary hair, acne, and adult-type body odor (ie, adrenarche). Adrenarche is benign except for the concern if often raises. It does not result in rapid growth, acceleration of the skeletal maturation, or short adult stature. No treatment is necessary except to differentiate it from congenital adrenal hyperplasia and to reassure parents that this process is in no way linked to early breast development or menarche.[1,2] Premature adrenarche occurs less frequently in boys; assessment of testicular size and levels of androgens of adrenal and testicular origin differentiate it from central precocious puberty.

Table 2. Radiologic Studies in the Evoluotion of Sexual Precocity

Radiologic Procedure	Use
Bone oge X-roy	Determinotion of biologic oge ond prediction of odult height
Ultrosound	Identification of tumors (testicular, odrenol, hepotic)
MRI	Identificotion of tumors (pituitory, testiculor, odrenol, hepatic)
CT	Identificotion of tumors (introcroniol, odrenal, hepotic)
Skeletol survey	Identification of bony lesions consistent with the McCune-Albright syndrome

Congenital Adrenal Hyperplasia

Congenital adrenal hyperplasia due to classic salt-wasting 21-hydroxylase deficiency is diagnosed early in life; females are often born with ambiguous genitalia and both sexes experience adrenal crisis secondary to salt wasting in the first days to weeks of life. However, milder forms of the disease may go undiagnosed until mid-childhood when evidence of androgen action becomes apparent. Girls typically present with evidence of adrenarche, but may also show signs of virilization such as clitoral enlargement. Boys generally present with phallic enlargement and pubic hair development, but testicular size remains prepubertal. In both genders linear growth is accelerated and skeletal maturation is advanced. Adequate suppression of adrenal androgens with corticosteroids is necessary for normal growth and preservation of adult stature.[3,4] Despite the institution of appropriate therapy, however, adult height may be compromised if the diagnosis is delayed.

Disorders of Autonomous Hormone Production

Disorders in this category, also referred to as gonadotropin-independent sexual precocity, include the McCune-Albright syndrome and testotoxicosis. The McCune-Albright syndrome is characterized by the triad of café-au-lait spots, fibrous dysplasia of long bones (cysts are seen on radiographic evaluation), and sexual precocity. Autonomous hormone production can also occur in other organs resulting in endocrinopathies such as thyrotoxicosis, giantism, and Cushing's syndrome. Affected endocrine organs have been shown to have a mutation in the $G_{3\alpha}$ subunit of the G_3 protein of the cyclic AMP pathway, resulting in spontaneous activation of adenyl cyclase and resultant autonomous endocrine function.[5] The pathogenesis of testotoxicosis is similar; mutations in the G protein of the testis effectively lock the LH receptor in the "on" position in the absence of ligand, resulting in autonomous testosterone production. This disorder is often familial, but new mutations also occur.[6]

Evaluation

Sex steroid hormones, whether of testicular, ovarian, or adrenal origin, result in accelerated growth, appearance of secondary sexual characteristics, advancement of skeletal age, and eventual short stature. The key to a favorable outcome is the timely identification of the etiology and institution of appropriate therapy.

The first step in the evaluation of sexual precocity is a careful review of the child's medical history and family background, including any relatives with early pubertal maturation or unusually short stature as adults. Review of systems should include questions regarding the frequency and character of headaches, changes in vision, acceleration of linear growth, abdominal/pelvic pain, increase in aggressive or moody behavior, and access to hormonal preparations. A complete physical examination should be performed with careful assessment of growth parameters, blood pressure, fundoscopic examination, dental development (often used as a rough indication of biologic age), acne, axillary hair, presence of abdominal masses or hepatomegaly, or skin lesions or pigmentation suggestive of the McCune-Albright syndrome, neurofibromatosis, or ACTH excess. Testicular size, appearance of the scrotum, and Tanner stage of the genitalia and pubic hair should be noted in boys, and Tanner stage of the breasts and pubic hair and appearance of the clitoris in girls. Evidence

of ongoing estrogen production may be easily gauged from the color of the lining of the vaginal introitis. Without estrogen stimulation the vaginal mucosa remains thin and vessels are easily seen, rendering it red and shiny. With progressively greater estrogen stimulation the mucosa thickens and changes from pink to whitish in appearance. This is perhaps even more specific than follicular activity seen on pelvic ultrasound which is also seen in normal prepubertal girls. If uterine enlargement and development of an endometrial stripe are present on ultrasound, however, significant estrogen stimulation is present.

Initial laboratory and radiologic work-up should include thyroid screening and assessment of skeletal maturation with a bone age x-ray (left hand and wrist). Other tests should be guided by the physical examination, as depicted in the accompanying tables and figures. It should be noted that early in the course of pubertal development, levels of sex steroid hormones, particularly testosterone, are highest early in the morning and wane throughout the day.[7] Timing of specimens should be in the morning if possible for the most accurate results. Stimulation tests are appropriate in the definitive diagnosis of central precocious puberty (GnRH stimulation test) or adrenal disorders (ACTH stimulation test).

Treatment

Premature thelarche and premature adrenarche are variations of normal development and do not require intervention, other than to educate the family about the process. Central precocious puberty is treated with gonadotropin-releasing hormone (GnRH) analogues, most commonly Depot Lupron. The rationale behind such treatment is that the process of puberty relies on a well defined pulsatile release of GnRH to stimulate the pituitary release of gonadotropins (LH and FSH). When a stable level of GnRH is present this process is shut down. GnRH analogue therapy is safe and slows growth and skeletal maturation to age appropriate rates. When the drug is discontinued, pubertal development resumes and future fertility is unimpaired.[8,9]

Congenital adrenal hyperplasia is managed with physiologic doses of hydrocortisone which act via feedback inhibition at the pituitary and hypothalamic levels to decrease ACTH production and subsequent adrenal hormone production. Adrenal insufficiency, a result of the disease and/or its treatment, necessitates that stress doses of corticosteroids are given during significant illnesses. Forms of congenital adrenal hyperplasia associated with salt loss require the addition of mineralocorticoid (Florinef).

Treatment of gonadotropin-independent sexual precocity is aimed at preventing steroid hormone synthesis in the gonad with ketoconazole, an antifungal with the useful side effect of inhibiting steroidogenesis.[10] Spironolactone may be added in males to reduce steroid hormone action at the target organ receptor,[11] and in females the aromatase inhibitor, testolactone, has been shown to be effective.[12] A potential side effect of globally inhibiting steroidogenesis is reduced cortisol synthesis and resultant adrenal insufficiency. In most cases this does not appear to be clinically significant, but warrants frequent monitoring.

An important concept to bear in mind is that the initial diagnosis and treatment of sexual precocity due to a peripheral rather than central cause is not necessarily the end to the story. Maturation of the skeletal age to around 13 years in males or 11 years in females, regardless of etiology, can trigger central precocious puberty, necessitating the addition of GnRH analogue therapy to the current treatment regimen.[13] Close follow-up, careful assessment of changes in growth and pubertal maturation, and an index of suspicion should prevail in the continuing care of these children.

References

1. Rosenfield RL. Normal and almost normal variants of precocious puberty: premature pubarche and premature thelarche revisited. *Horm Res.* 1994;41:7-13.
2. Ibanez L, Virdis R, Potau N, et al. Natural history of premature pubarche: an auxological study. *J Clin Endrocrinol Metab.* 1992;74:254-257.
3. Laue L, Cutler GB Jr. 21-hydroxylase deficiency: overview of treatment. *Endocrinologist.* 1992;2:291-300.
4. New MI, Rapaport R. Congenital adrenal hyperplasia. In: Sperling MA, ed. *Pediatric Endocrinology.* Philadelphia, Pa: WB Saunders; 1996:283-296.
5. Weinstein LS, Shenker A, Gejman PV, Merino MJ, Friedman E, Spiegel AM. Activating mutations of the stimulatory G protein in the McCune-Albright syndrome. *New Eng J Med.* 1991;325:1688-1695.
6. Clark PA, Clarke WL. Testotoxicosis: An unusual presentation and novel gene mutation. *Clin Pediatr.* 1995;34(5):271-274.
7. Goji K, Tanikaze S. Spontaneous gonadotropin and testosterone concentration profiles in prepubertal and pubertal boys: temporal relationship between luteinizing hormone and testosterone. *Pediatr Res.* 1993;34:229-236.
8. Neely EK, Hintz RL, Parker B, et al. Two-year results of treatment with depot leuprolide acetate for central precocious puberty. *J Pediatr.* 1992;121:634-640.
9. Jay N, Mansfield MJ, Blizzard RM, et al. Ovulation and menstrual function of adolescent girls with central precocious puberty after therapy with gonadotropin-releasing hormone

agonists. *J Clin Endocrinol Metab.* 1992;75:890-894.
10. Sonino N. The use of ketoconazole as an inhibitor of steroid production. *New Eng J Med.* 1987;317:812-818.
11. Stripp B, Taylor AA, Bartter FC, et al. Effect of spironolactone on sex hormones in man. *J Clin Endrocrinol Metab.* 1975;41:777-781.
12. Feuillan PP, Jones J, Cutler GB Jr. Long term testolactone therapy for precocious puberty in girls with the McCune-Albright syndrome. *J Clin Endocrinol Metab.* 1993;77:647-651.
13. Holland FJ, Kirsh SE, Selby R. Gonadotropin-independent precocious puberty ("Testotoxicosis"): influence of maturational status on response to ketoconazole. *J Clin Endocrinol Metab.* 1987;64:328-332.

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Treatment of Cryptococcal Arthritis With Fluconazole Monotherapy

Frank Lee, MD; Pran M. Kar, MD, FACP; George R. Aronoff, MD, FACP

Cryptococcus neoformans is a yeast-like soil organism that typically infects immunocompromised patients. It usually causes symptomatic infection of the meninges. However, 20% to 30% of patients with cryptococcal infection present with involvement of the lungs, skin, bone, eye, or urinary tract, with or without meningitis.[7] Isolated infection of the knee without cryptococcal osteomyelitis is rare.[2] Systemic cryptococcal infection is usually treated with intravenous amphotericin. We report the first successful treatment of cryptococcal arthritis with fluconazole monotherapy.

Case Presentation

A 63-year-old African American man complained of a 20 pound weight loss over 3 months and progressive right knee pain, swelling, and erythema for 6 weeks. He complained of nausea and vomiting for 2 weeks. One week before admission he developed fever and lower extremity edema.

The patient's past medical history included well controlled hypertension of more than 20 years duration and a transurethral resection of the prostate for benign prostatic hypertrophy. Twenty-two years earlier, a lung biopsy was reported as sarcoidosis. His medications included only isradipine and guanfacine hydrochloride. The patient was a retired musician and had not traveled outside of the United States. He had no pets, but admitted to feeding pigeons as a hobby.

His temperature was 99.3° F. His blood pressure was 140/70 mmHg and his pulse was 90 beats per minute. He was breathing 22 times per minute. He was cachectic and appeared ill. Marked arteriovenous nicking of the retinal vasculature was present on fundoscopic examination. The jugular veins were distended to 2 cm and a soft systolic murmur was heard at the left upper sternal border. Rales were present in the lung bases bilaterally. His right knee was swollen, tender, and erythematous. Motion of the joint caused severe pain.

His hemoglobin was 10.5 grams and his BUN and creatinine were 186 mg/dl and 14 mg/dl, respectively. Degenerative changes and a joint effusion were seen on x-ray of the right knee, but there was no evidence of osteomyelitis. Arthrocentesis produced 20 ml of purulent fluid. There were no crystals. The leukocyte count in the joint fluid was 71,700/mm^3 with 85% of those cells being polymorphonuclear leukocytes. Gram stain did not show bacteria, but yeast was present on microscopic fungal preparation. Joint fluid culture grew *Cryptococcus neoformans*. Lumbar puncture was negative and cryptococcal antigen was not detected in the CSF. However, the serum cryptococcal antigen titer was 1:512. His HIV and hepatitis B and C serologies were negative.

The patient was hemodialyzed regularly for renal failure. Because of the patient's renal failure and to prevent potential further renal injury, he was treated with fluconazole 400 mg intravenously every other day instead of amphotericin. After 7 days his joint pain, fever, erythema, and effusion had resolved and he was discharged on fluconazole 200 mg orally for 6 months duration. After 20 months, he had no recurrence of arthritis and his serum cryptococcal antigen remained negative. He has continued to require chronic hemodialysis treatments.

Discussion

Cryptococcus is an encapsulated basidiomycetous yeast-like fungus with two varieties that cause infection in man, *Cryptococcus* var *neoformans* and *Cryptococcus* var *gattii*. Both fungi are removed from the environment by the action of sunlight and other microorganisms. They are endemic in birds, particularly pigeons. *C neoformans* usually causes asymptomatic pulmonary infection.[4] Disseminated infection occurs in immunocompromised patients. Of the two variants, *Cryptococcus gattii* causes less serious infection and is rarely associated with AIDS.[7]

The observation of typical yeast-like fungi on microscopic fungal stains or India ink preparation

and the presence of cryptococcal antigen in body fluids suggest cryptococcal infection. Culture of the organism confirms the diagnosis.[1] Standard treatment of systemic cryptococcal infection includes Amphotericin B alone or in combination with flucytosine.[3]

However, intravenous amphotericin is associated with systemic toxicity. Nearly 80% of patients treated with amphotericin for disseminated fungal infections develop renal dysfunction.[9] The combination of amphotericin and flucytosine may enhance eradication of the organism with decreased nephrotoxicity.[8]

Recent reports suggest that the triazole antifungal drugs fluconazole and itraconazole may effectively treat cryptococcal infection. Patients with cryptococcal meningitis have been successfully treated with either drug, and laryngeal cryptococcal infection has been treated with oral fluconazole.[5,6,8] We report the first successful treatment of cryptococcal arthritis with fluconazole.

References

1. Anderson DJ, Schmidt C, Goodman J, Pomeroy C. Cryptococcal disease presenting as cellulitis. *Clin Infect Dis.* 1992; 14:666-672.
2. Behrman RE, Masci JR, Nicholas P. Cryptococcal skeletal infections: case report and review. *Rev Infect Dis.* 1990;12(2): 181-190.
3. Bennett SE, Dismukes WE, Duma RJ, et al. A comparison of Amphotericin B alone and combined with flucytosine in the treatment of cryptococcal meningitis. *N Eng J Med.* 1979; 301:126-131.
4. Bunning RD, Barth W. Cryptococcal arthritis and cellulitis. *Ann Rheum Dis.* 1984;43:508-510.
5. Cauwenberg C. Cryptococcal meningitis: the place of itraconazole. *Mycoses.* 1993;36(7-8):221-228.
6. Kerschner JE, Ridley MB, Greene JN. Laryngeal cryptococcus: treatment with oral fluconazole. *Arch Otolaryngol Head Neck Surg.* 1995;121:1193-1195.
7. Saag M. Editorial response: clinical and host differences between infections with the two varieties of *Cryptococcus neoformans. Clin Infect Dis.* 1995;21:35-36.
8. Sugar AM, Stern JJ, Dupont B. Overview: treatment of cryptococcal meningitis. *Rev Infect Dis.* 1990;12(3):S338-348.
9. Utz JP, moderator. Amphotericin B toxicity. *Ann Intern Med.* 1964;61:334-354.

Cigarette Smoking in Kentucky: Smoking-Attributable Mortality and Years of Potential Life Lost

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To measure the adverse impact of smoking in Kentucky, a major tobacco-growing state with the nation's highest prevalence of smokers ages 18 and over, percentages of deaths and years of potential life lost attributable to smoking were estimated. Summaries of the analyses for Kentucky in 1996 are presented. These show that 23% of all deaths in Kentucky were attributable to smoking, compared to 19.5% for the nation. Because most smoking-related illnesses develop over a long time, Kentucky can expect to continue to have a substantial excess of smoking-attributable deaths in the future.

Cigarette smoking is the leading preventable cause of disease and premature death in the United States.[1] Since the national Behavioral Risk Factor Surveillance System (BRFSS) was begun in 1985, Kentucky's prevalence of current smokers has ranked at or near the top of states surveyed.[2] Results from the 1996 BRFSS indicated that 31.6% of Kentuckians over 18 years of age were current smokers, the highest prevalence of all the states. This compares with a median prevalence of 23.5% for the 50 participating states and the District of Columbia.[3] A *Healthy Kentuckians 2000* objective is to reduce cigarette smoking to a prevalence of no more than 23% among Kentuckians 18 and older.[4]

Burley tobacco is Kentucky's number one cash crop, and the tobacco industry is a major employer throughout the state. Burley production was 399 million pounds in 1997.[5] To measure the adverse impact of smoking in a major tobacco-growing state, the Division of Epidemiology and Health Planning periodically estimates the smoking-attributable mortality (SAM), smoking-attributable fraction (SAF), and years of potential life lost (YPLL). Summaries of the analyses for Kentucky in 1996 are presented.

Methods

SAMMEC 3.0 computer software[6] was used to calculate SAM, SAF, and YPLL. Calculations were made for 22 smoking-related diseases among adults ages 35 years or more, smoking-related burn fatalities for all ages, and four perinatal conditions related to maternal smoking. Mortality data for 1996 were obtained from the Kentucky vital records system. The estimated prevalence of cigarette smoking for 1996 was calculated from the Kentucky BRFSS.

SAM was computed by multiplying the number of gender- and cause-specific deaths by the SAF. SAF is a system for weighting figures using past, current, and never smokers.[7] YPLL was calculated by summing the product of gender- and age-specific deaths by years of potential life remaining. Years of potential life remaining figures were obtained from life tables prepared by the National Center for Health Statistics.[8]

Results

In 1996, 23% of all deaths in Kentucky were attributable to smoking (Table 1). The comparable figure for the nation was 19.5% using 1990-1994 calculations, the latest years for which data are available.[9] Thirty-one percent of Kentuckians whose deaths were attributable to smoking were younger than 65 years of age.

As indicated by comparing Tables 2 and 3, SAM was higher for men than for women (29% among men compared to 17% among women). In 1992, these percentages were 29% and 15% respectively.[10]

Lung cancer accounted for 31% of overall smoking-attributable mortality (Table 1). For males the percentage was 33% (Table 2); for females 28% (Table 3). Ischemic heart disease was responsible

for 20% of overall smoking-attributable deaths; chronic airways obstruction for 15%.

Analysis of 1996 data shows that 124,150 YPLL (based on life expectancy) were attributable to smoking (Table 4), an increase from 101,145 YPLL in 1992. The 1996 data show that persons younger than 65 years of age accounted for 54% of YPLL. Of total YPLL, 61% were in men while 39% were in women. In 1992, 65% of YPLL were in men and 35% were in women. The average YPLL per smoking-attributable death in 1996 was 14 years. In 1992 this figure was 13 years.

Discussion

Kentucky mortality data emphasize the impact of cigarette smoking on premature mortality in a state with a high prevalence of tobacco use. YPLL due to smoking are excessive. Special concerns are that 31% of smoking-attributable deaths and 54% of YPLL were among persons younger than 65 years of age; also the percentage of both smoking-attributable deaths for women and YPLL for women increased from 1992. Because most smoking-related illnesses develop over a long time, Kentucky can

Table 1. Estimated Smaking-Attributable Martality (SAM) and Smoking-Attributable Fraction (SAF) by Cause af Death, Kentucky, 1996 — Overall Papulatian

Cause af Death (ICD-9 Rubric)	Tatal Deaths	Crude SAF	SAM
Neaplasms			
Lip, Oral Cavity, Pharynx (140-149)	118	0.81	95
Esaphagus (150)	151	0.77	117
Pancreas (157)	423	0.27	115
Larynx (161)	75	0.84	63
Trachea, Lung, Branchus (162)	3,123	0.85	2,645
Cervix Uteri (180)	89	0.33	29
Urinary Bladder (188)	170	0.41	70
Kidney, Other Urinary (189)	214	0.33	71
Tatal	4,363	0.73	3,205
Cardiavascular Diseases			
Hypertensian (401-404)	473	0.19	88
Ischemic Heart Disease (410-414)			
Persans Aged 35-64	1,570	0.46	727
Persans Aged 65+	5,866	0.18	1,031
Other Heart Disease (390-398, 415-417, 420-429)	4,008	0.19	779
Cerebravascular Disease (430-438)			
Persans Aged 35-64	328	0.54	177
Persans Aged 65+	2,311	0.14	315
Atherasclerasis (440)	172	0.40	69
Aartic Aneurysm (441)	252	0.48	121
Other Arterial Disease (442-448)	192	0.43	82
Tatal	15,172	0.22	3,389
Respiratary Diseases			
Pneumania, Influenza (480-487)	1,349	0.27	367
Branchitis, Emphysema (490-492)	313	0.81	254
Chranic Airways Obstructian (496)	1,573	0.81	1,275
Other Respiratary Diseases (10-12, 493)	79	0.29	23
Tatal	3,314	0.58	1,919
Perinatal Canditians			
Shart Gestatian/Law Birth Weigh (765)	84	0.20	17
Respiratary Distress Syndrame (769)	6	0.17	1
Respiratary Canditions—Newbarn (770)	9	0.11	1
Sudden Infant Death Syndrame (798)	44	0.14	6
Tatal	143	0.17	25
Burn Deaths	87	0.49	43
All Other Causes	14,114		
TOTAL	**37,193**	**0.23**	**8,581**

expect to continue to have a substantial excess of smoking-attributable deaths in the future.

Health officials in Kentucky are committed to reducing the prevalence of smoking. Disease impact estimation is an important consideration in planning public health efforts. Increasing the awareness of the consequences of active and passive smoking is imperative. These data support the need to focus smoking cessation efforts among younger persons before the onset of chronic disease associated with smoking.

References

1. Centers for Disease Control: *Reducing the health consequences of smoking: 25 years of progress—a report of the Surgeon General.* Rockville, MD. US Department of Health and Human Services, Public Health Services, DHHS publication (CDC)89-8411;1989.
2. Centers for Disease Control and Prevention: 1985-1996 BRFSS summary prevalence reports. Atlanta, GA. US Department of Health and Human Services, Public Health Services.
3. Centers for Disease Control and Prevention: 1996 BRFSS summary prevalence report. Atlanta, GA. US Department of Health and Human Services, Public Health Services; 1997.

Table 2. Estimated Smoking-Attributable Martality (SAM) and Smoking-Attributable Fractian (SAF) by Cause of Death, Kentucky, 1996 — Males

Cause af Death (ICD-9 Rubric)	Total Deaths	Crude SAF	SAM
Neoplasms			
Lip, Oral Cavity, Pharynx (140-149)	75	0.92	69
Esophagus (150)	117	0.80	94
Pancreas (157)	210	0.25	52
Larynx (161)	52	0.81	42
Trachea, Lung, Branchus (162)	1,967	0.90	1,774
Cervix Uteri (180)	N/A		N/A
Urinary Bladder (188)	116	0.46	53
Kidney, Other Urinary (189)	132	0.48	64
Tatal	2,669	0.80	2,148
Cardiavascular Diseases			
Hypertensian (401-404)	196	0.27	52
Ischemic Heart Disease (410-414)			
Persans Aged 35-64	1,161	0.48	555
Persans Aged 65+	2,809	0.21	602
Other Heart Disease (390-398, 415-417, 420-429)	1,745	0.26	462
Cerebravascular Disease (430-438)			
Persans Aged 35-64	187	0.52	97
Persans Aged 65+	842	0.25	207
Atherasclerosis (440)	70	0.59	41
Aartic Aneurysm (441)	169	0.57	97
Other Arterial Disease (442-448)	96	0.57	55
Tatal	7,275	0.30	2,168
Respiratary Diseases			
Pneumania, Influenza (480-487)	613	0.33	202
Branchitis, Emphysema (490-492)	168	0.86	144
Chranic Airways Obstructian (496)	876	0.85	746
Other Respiratary Diseases (10-12, 493)	32	0.28	9
Tatal	1,689	0.65	1,101
Perinatal Canditians			
Short Gestatian/Law Birth Weigh (765)	48	0.21	10
Respiratary Distress Syndrame (769)	2	0.00	0
Respiratary Canditions—Newborn (770)	7	0.14	1
Sudden Infant Death Syndrome (798)	26	0.15	4
Tatal	83	0.18	15
Burn Deaths	50	0.48	24
All Other Causes	7,138		
TOTAL	**18,904**	**0.29**	**5,456**

Table 3. Estimated Smoking-Attributable Mortality (SAM) and Smoking-Attributable Fraction (SAF) by Cause of Death, Kentucky, 1996 — Females

Cause of Death (ICD-9 Rubric)	Total Deaths	Crude SAF	SAM
Neoplasms			
Lip, Oral Cavity, Pharynx (140-149)	43	0.60	26
Esophagus (150)	34	0.68	23
Pancreas (157)	213	0.30	63
Larynx (161)	23	0.91	21
Trachea, Lung, Bronchus (162)	1,156	0.75	871
Cervix Uteri (180)	89	0.33	29
Urinary Bladder (188)	54	0.31	17
Kidney, Other Urinary (189)	82	0.09	7
Total	1,694	0.62	1,057
Cardiovascular Diseases			
Hypertension (401-404)	277	0.13	36
Ischemic Heart Disease (410-414)			
Persons Aged 35-64	409	0.42	172
Persons Aged 65+	3,057	0.14	429
Other Heart Disease (390-398, 415-417, 420-429)	2,263	0.14	317
Cerebrovascular Disease (430-438)			
Persons Aged 35-64	141	0.57	80
Persons Aged 65+	1,469	0.07	108
Atherosclerosis (440)	102	0.27	28
Aortic Aneurysm (441)	83	0.29	24
Other Arterial Disease (442-448)	96	0.28	27
Total	7,897	0.15	1,221
Respiratory Diseases			
Pneumonia, Influenza (480-487)	736	0.22	165
Bronchitis, Emphysema (490-492)	145	0.76	110
Chronic Airways Obstruction (496)	697	0.76	529
Other Respiratory Diseases (10-12, 493)	47	0.30	14
Total	1,625	0.50	818
Perinatal Conditions			
Short Gestation/Low Birth Weigh (765)	36	0.19	7
Respiratory Distress Syndrome (769)	4	0.25	1
Respiratory Conditions—Newborn (770)	2	0.00	0
Sudden Infant Death Syndrome (798)	18	0.11	2
Total	60	0.17	10
Burn Deaths	37	0.51	19
All Other Causes	6,976		
TOTAL	**18,289**	**0.17**	**3,125**

4. Kentucky Department for Health Services: *Healthy Kentuckians 2000: Kentucky's public health objectives for the year 2000.* Frankfort, KY. Kentucky Cabinet for Human Resources; 1991.
5. Kentucky Agricultural Statistics Service: Kentucky agricultural statistics, Louisville, KY. Kentucky Department of Agriculture; 1997.
6. Schultz JM, Novotny TE, Rice DP. *SAMMEC 3.0: smoking-attributable mortality, morbidity, and economic costs computer software and documentation.* Atlanta, GA. US Department of Health and Human Services, Public Health Service; August 1996.
7. Ibid
8. National Center for Health Statistics: Vital statistics of the United States, 1991: life tables. Hyattsville, MD. US Department of Health and Human Services, Public Health Service; 1995.
9. Centers for Disease Control and Prevention: Smoking-attributable mortality and years of potential life lost—United States, 1984. *MMWR* 1997;46:449.
10. Hughes JP, Stapleton MP. Cigarette smoking in Kentucky: progress toward year 2000 objectives and reduction of smoking-attributable mortality. *South Med J.* 1994;87:696-701.

Table 4. Estimated Smoking-Attributable Years of Potential Life Lost (YPLL) by Cause of Death and Gender, Kentucky, 1996

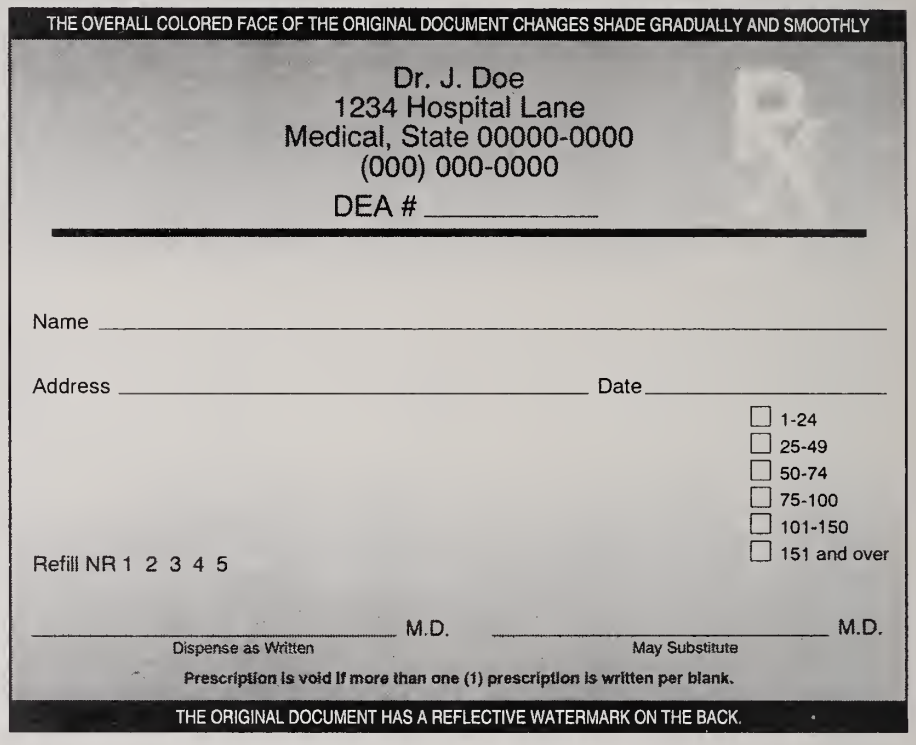
Cause of Death (ICD-9 Rubric)	Male	Female	Total
Neoplasms			
Lip, Oral Cavity, Pharynx (140-149)	1,304	449	1,753
Esophagus (150)	1,458	350	1,808
Pancreas (157)	789	979	1,768
Larynx (161)	619	361	980
Trachea, Lung, Bronchus (162)	25,372	15,632	41,004
Cervix Uteri (180)	N/A	720	720
Urinary Bladder (188)	633	224	857
Kidney, Other Urinary (189)	964	133	1,097
Total	31,139	18,848	49,987
Cardiovascular Diseases			
Hypertension (401-404)	719	464	1,183
Ischemic Heart Disease (410-414)			
Persons Aged 35-64	13,088	4,705	17,793
Persons Aged 65+	5,348	4,004	9,352
Other Heart Disease (390-398, 415-417, 420-429)	5,851	3,758	9,609
Cerebrovascular Disease (430-438)			
Persons Aged 35-64	2,362	2,275	4,637
Persons Aged 65+	1,637	940	2,577
Atherosclerosis (440)	360	266	626
Aortic Aneurysm (441)	1,290	351	1,641
Other Arterial Disease (442-448)	722	400	1,122
Total	31,377	17,163	48,540
Respiratory Diseases			
Pneumonia, Influenza (480-487)	1,983	1,619	3,602
Bronchitis, Emphysema (490-492)	1,695	1,559	3,254
Chronic Airways Obstruction (496)	7,646	7,173	14,819
Other Respiratory Diseases (10-12, 493)	221	252	473
Total	11,545	10,603	22,148
Perinatal Conditions			
Short Gestation/Low Birth Weigh (765)	715	587	1,302
Respiratory Distress Syndrome (769)	30	65	95
Respiratory Conditions—Newborn (770)	104	33	137
Sudden Infant Death Syndrome (798)	253	127	380
Total	1,102	812	1,914
Burn Deaths	857	704	1,561
TOTAL	**76,020**	**48,130**	**124,150**

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Dealing With "Excluded Providers": Contracts That Can Bring Trouble to Physicians

Patrick T. Padgett

Congress passed a series of laws in 1997 giving federal agencies more authority, as well as incentives, to conduct investigations of medical providers for alleged instances of "fraud and abuse." One of those laws also forces providers to police themselves. The Balanced Budget Act of 1997 prohibits medical providers, as well as physicians, from contracting with anyone who has been "excluded" from participation in a federal health care program.[1] If a physician, therefore, contracts with another entity that has been excluded from a federal health care program, the government can impose penalties on the physician. This article discusses that law as well as steps a physician can take to help prevent an inadvertent violation of the law.

The Law

The Balanced Budget Act of 1997 created a law that penalizes a person, including a physician, who

> *arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a federal health care program . . . for the provision of items or services for which payment may be made under such a program.*[2]

In order for a physician to violate this law, three things must occur. First, the physician must have a contract or "arrangement" with another individual or entity. The law is not limited to written contracts. It also includes arrangements such as referrals and orders for supplies. Physicians, therefore, should assume that any "arrangement" is subject to the law.

Secondly, the individual or entity with which the physician has an arrangement must have been excluded from a federal health care program. A federal health care program is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, as well as any state health care program, such as Medicaid.[3]

Finally, the physician or excluded provider must provide services for which payment is made by a federal health care program. It is sometimes difficult to know whether a patient is in a federal health care program because such programs may use names that do not indicate they are being funded by the government. (For instance, the Mailhandlers Benefit Plan is a federal health care program.) It is best to assume, therefore, that all patients are covered by federal health care programs.

Potential Penalties

There are two types of penalties a physician may receive for having arrangements with providers that have been excluded from federal health care programs. First, the physician who has an arrangement with an excluded provider can himself be excluded from federal health care programs.[4] Such an exclusion could damage a practice that depends heavily on federal health care programs for payment. It could also lead to a physician being excluded from other programs since the exclusion from federal health care programs will most likely be reported to the national practitioner databank.

The government may also impose a "civil money penalty" on a physician for contracting with an excluded provider. A civil money penalty is imposed on a physician by the Secretary of the Department of Health and Human Services and can be as much as $10,000.[5] The physician who receives such a penalty has the right to an administrative hearing, which is conducted by an administrative law judge who works for the Department of Health and Human Services. If the administrative law judge upholds the imposition of money penalties, the decision can then be appealed to the Departmental Appeals Board within the Department of Health and Human Services.[6] Consideration by the Appeals Board is discretionary. If the Board upholds the money penalty, the Secretary may then impose the penalty. The physician may then appeal to the United States Court of Appeals, which may review the matter if it chooses.[7]

Protections for Physicians

Since there are harsh penalties for violating this law, physicians should take steps to protect themselves. The

steps outlined below may help physicians ensure they do not have an illegal arrangement with another provider or entity.

Step 1: A physician should assume that any contract or "arrangement" which he or she may have is subject to the law. Such arrangements may be with third-party payors, hospitals, networks, pharmacies, nursing homes, drug companies, nurse practitioners, physician assistants, or other physicians.

Step 2: A physician should research whether the other party to an agreement has been excluded since the law penalizes physicians who "should have known" the other provider was excluded. One way a physician can find this out is by checking various government web sites. One such web site, http://www.dhhs.gov/progorg/oig, was established by the Department of Health and Human Services' Office of Inspector General. There is a section in the left-hand column of that web site called "Cumulative Sanctions" that covers individuals and organizations barred from Medicare and Medicaid programs. Another web site, http://www.arnet.gov/epls, contains a report called "Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs." This web site was established by the General Services Administration and lists individuals and entities barred from programs besides Medicare and Medicaid. The problem with these web sites is that the government is very far behind in tracking and listing excluded providers.[8] Therefore, physicians should also take other steps to protect themselves.

Step 3: If a physician has a written contract with another entity or provider, the physician should ensure that language is inserted in the contract certifying that the entity or provider has not been excluded from federal health care programs. Such a provision could read something like the following:

> *[Provider or entity] certifies that it has never been excluded from participation in any federal health care program, as defined under 42 USC §1320a-7b (f) and, to [provider or entity]'s knowledge, there are no pending or threatened governmental actions that may lead to such exclusion. [Provider or entity] shall notify physician of the commencement of any such exclusion or investigation within seven days of [provider or entity] first learning of it. Physician shall have the right to terminate this agreement immediately upon notification of such exclusion or investigation.*

Step 4: If a physician cannot find out whether a particular entity or provider has been excluded from a federal health care program and the physician does not have a written contract with the entity, the physician should try to get a certification from the provider that it has not been excluded. To do this, the physician should send a letter that contains language similar to the contract provision cited above and have the entity or provider sign the provision and send it back. If the provider or entity does not send the document back to the physician, the physician should follow up and find out the status of the certification.

Step 5: The law might also be violated if a physician hires an employee who has been excluded from a federal health care program. Such a violation is especially likely with the increasing use of nurse practitioners and physician assistants within the Medicare program. The physician should check to see if the employee has been excluded from federal health care programs and should also have the employee certify in writing that he or she has not been excluded from federal health care programs, using language similar to the language discussed above.

Conclusion

The law now imposes an obligation on physicians to ensure they have no arrangements with excluded providers. While this "self-policing" mechanism may be burdensome, physicians can take simple measures to protect themselves. Otherwise, a physician might find himself labeled as an "excluded provider."

References

1. PL 105-33 §4304
2. 42 USC §1320a-7a(a)(6)
3. 42 USC §1320a-7b(f)
4. 42 USC §1320a-7a(a)
5. Id
6. 42 USC §1320a-7a(c)(2)
7. 42 USC §1320a-7a(e)
8. *Medicare Compliance Alert,* Vol 9, NO. 16, August 11, 1997, P 3

Mr Padgett is Director, Socioeconomic Affairs/Staff Counsel for the Kentucky Medical Association.

The Elixir of Hope

My 73-year-old widowed farmer found himself a new girl friend from Alabama who comes to his town of Brimstone to visit her mother. He even went to Alabama to visit her. He was unable to consummate their friendship so he came to me for a prescription for Viagra. On his girl friend's return to Brimstone, she prohibited his use of the Viagra ostensibly because she wanted to protect him from the resulting heart attack. Since his heart has never attacked him and he still bales hay, one is forced to conclude that she prefers to live without sexual activity. Fortunately he has not crumpled into the corner of the farm house in despair but is cruising Brimstone's Friday night eatery in search of a widow who wants to live the way he does.

Hooray for the resurrection of the dead!

A. Evan Overstreet, MD
Editor



YOU CAN EARN GREAT REWARDS FOR RECRUITING YOUR PEERS



The Kentucky Medical Association Member-Get-A-Member Campaign . . .

is designed to assist you in locating and contacting non-members in your area. You may choose to recruit any physician in your area who has completed medical training and is in active practice, eg, hospital staff colleagues, alumni from your medical school, physicians in your specialty, or nonmembers in a particular target group.

The most effective way to recruit new members is through a personal conversation or note conveying your own thoughts about why you are a member. You will receive a Recruitment Kit containing support materials when you sign up.

KMA will recognize the outstanding physician recruiters by awarding gifts based on the number of new members recruited.

KMA awards for:

Members who recruit:	*Earn*
1-3 new active members	Leather Attache
4-6 new active members	35mm Camera
7-9 new active members	Digital Camera
10+ new active members	Laptop Computer

Complete this form and return to Kentucky Medical Association Membership Department to get started today.

Name _____

Address _____

City, State, Zip_____ Phone _____

Please provide me with a list of potential members based on the following categories:

County: _____ Specialty: _____

Gender: _____ Medical School: _____

Mail to: KMA Membership Dept., 4965 US Hwy 42, Ste 2000, Louisville KY 40222. Or call, (502) 426-6200.



Jan Crase

Hail to the Chief!

The Chief of whom I speak never heard of Monica Lewinsky—Pocahontas maybe, but not Monica. This chief showed up in Plymouth, Massachusetts in 1621 to help a bunch of stragglers, who had survived a dreadful winter that had killed about half the members of the colony, to celebrate a bountiful harvest. His name was Chief Massasoit. He was Chief of the Wampanoag Tribe of Indians that lived in what is now southern Massachusetts and Rhode Island. Chief Massasoit made a treaty with Governor Carver that agreed his people would not harm the Pilgrims and in turn the Pilgrims guaranteed to protect the Indians and their rights. Massasoit kept the peace as long as he lived.

The Thanksgiving festival lasted three days and Chief Massasoit and his Indian companions brought food, including five deer, to add to the feast. Many of you can identify with Massasoit in that you have shared of your bountiful harvest and each time you have done so, you have contributed to the spirit of that First Thanksgiving in New England. The KMA Alliance has been at your side at the harvest table and continues to do so at this Thanksgiving Season — and the Chief smiles.

In the spirit of the Season, the KMA Alliance celebrates one of its latest accomplishments and prepares for an even more bountiful sharing at the harvest table in the future. Many members of the Alliance recall when our spouses received scholarships while in medical schools and how much those funds meant at that time. As a way of expressing our gratitude and passing on to others the privileges that were afforded to our spouses and us, a KMAA scholarship was established at each of the two Kentucky medical schools in September, with funds raised by Alliance members for the AMA Foundation. The KMAA has a very long and rich history of fund raising for the AMA Foundation, (formerly known as AMA/ERF and whose name changed only this year) and we want to bring more of these future funds back to "Kaintucke." Contributions made to the AMA Foundation can be designated for either the U of L or U of K scholarship and will go from the AMA directly to those scholarship funds. Many of you contribute to the AMA Foundation, so please keep that in mind. The Alliance appreciates all your support of the many fund raising activities over the

many years—the Chief would be proud.

Some of the numerous fund raisers now underway by the Alliance to benefit the AMA Foundation and scholarships are: A state wide Christmas sharing card for doctors and their spouses to send Christmas greetings to each other — Most counties are doing county greeting cards as well — Sale of multi purpose note cards with water colors by Carolyn Daley — A special limited edition Norman Rockwell card is being sold — A master quilter from Boyd County is quilting a beautiful quilt which is being raffled for $25 per ticket — Some County Alliances have already had golf tournaments to raise funds and some are planning basket auctions. The Alliance is working very hard to help make a positive difference in the lives of future medical students. We welcome you to join us in showing thanks by sharing—Massasoit would be mesmerized by all this activity.

The Chief understood the importance of participation as he brought 90 Indians with him to the Thanksgiving Festival. We also need participation. The entire medical family is invited to this symbolic Thanksgiving table to share the harvest. If your spouse is not a member of the KMAA, please complete this form and send with dues to the KMAA. For Thanksgiving, give your spouse a ticket to the Harvest table — Massasoit would approve.

Jan Crase
KMAA President

---------- *cut along this line* ----------

TICKET TO THE HARVEST TABLE

KMA Alliance Membership application

Spouse Name	Home address	City	Zip code
Physician Name	Office address	City	Zip code
Home phone	Home fax	Office phone	Office fax

DUES:
National..... $25
State..... $15
County..... *Varies* if your county is organized (check with the County President)
None if your county does not have an organized Alliance

Mail completed form plus dues to KMAA 4965 US HWY 42, Suite 2000, Louisville, KY 40222-6301.

PEOPLE

William F. Gee, MD, Lexington, was named 1997-98 President of the American Association of Clinical Urologists. This is the national political organization of urologists with 4,300 members.

The Louisville pediatric practice of **Martin Z. Kaplan, MD; Bernard W. Barron, MD; John B. Roth, MD; Ronald Lehocky, MD; David S. Katz, MD; James R. Belza, MD; Karen J. Abrams, MD;** and **Rosalyn G. Sarmiento, MD,** is celebrating 50 years of providing medical care to children and youth of Kentuckiana.

Dr Kaplan founded the practice in 1948. It has since provided more than 100,000 children medical care on many levels. Upon retiring in 1987, Dr Kaplan was recognized by the Kentucky Commission for Handicapped Children as a pioneer in providing private medical care for special needs children.

The University of Louisville Associate Dean for Faculty and Student Advocacy **Leah Dickstein, MD,** recently published a guide to her Health Awareness Workshop to help other schools nationwide implement her beneficial program.

The workshop is designed for entering medical students to learn more about healthy living habits before they become immersed in their medical training. It also serves as a comfortable setting in which the students can get to know each other outside the stresses of class.

Stephen Kirzinger, MD, Louisville, was elected July Volunteer of the Month for the National Multiple Sclerosis Society (NMSS), through the Kentucky Chapter.

Dr Kirzinger is an active member of the Board of Trustees, Executive Committee, and the Professional Advisory Committee for the Kentucky Multiple Sclerosis Society. He is also medical director of the Baptist Hospital East MS Clinic, an affiliate of the National Consortium of MS Clinics. Dr Kirzinger recently completed service as the Chair of the Programs and Education Committee at that clinic.

Billy F. Andrews, MD, Louisville, was appointed Visiting Fellow of Green College, University of Oxford, where he was a special guest in February. Dr Andrews was professor and Chair of the Department of Pediatrics at the University of Louisville School of Medicine and Chief of Staff at Kosair Children's Hospital from 1969 to 1993.

He officially retired on June 30, 1998, but remains on the faculty part-time to continue to care for infants and children with inborn errors of metabolism such as PKU and galactosemia and to pursue his interest in medical history and ethics.

UPDATES

Legal Issues

Waivers of Copays and Deductibles. There have been many questions regarding the ability of a physician's office to waive copays and deductibles. Such a practice may be illegal except in the case of indigent patients. The US Department of Health and Human Services Office of Inspector General published an "alert" on this issue a few years ago. If you would like a copy of the alert, you can access the OIG's web page at *www.dhhs.gov/progorg/oig/* and click on "fraud alerts." Or, contact the KMA legal department.

Sexual Harassment. Sexual harassment in the workplace continues to be a hot issue for all employers. Recent studies regarding physicians and harassment has now brought the issue into the medical community. KMA has drafted a paper on sexual harassment and what employers should do to try and avoid such problems. KMA has also drafted a sample "Sexual Harassment Policy for Physician Offices." If you would like a copy of this document, contact the KMA legal department.

The legal department may be contacted by phone, fax, or email *(padgett@kyma.org) (phelps@kyma.org).*

Note from the Department of Public Health

Tuberculosis outbreaks in two Kentucky nursing homes this year serve as a reminder to physicians that while TB is on the decline among most populations, elderly people in nursing homes are more at risk than the general public. Three cases occurred in Mason County and four cases in Green County. TB among nursing home residents often is mistaken for pneumonia, a chronic cough, or bronchitis, and antituberculosis treatment is not administered. Doctors are asked to consider TB in the differential diagnosis of lower respiratory tract disease in nursing home residents. They are more vulnerable to TB than senior citizens living in the community because they are in close quarters and generally have poor health that can reactivate previous infection. For more information on TB control, call 502.564.4276.

KMA Urges Support of Doctor Smokestopper Project

Primary care physicians will be getting calls and visits from volunteers working with the Regional Prevention Centers for the Doctor Smokestopper project. The volunteers will schedule five-minute appointments to discuss the impact of smoking cessation counseling by physicians and to provide patient education materials for physician use.

The statewide project is a public health collaboration between the Kentucky Medical Association, the Department for Public Health, and the Division of Substance Abuse. The KMA Board of Trustees endorsed this project and encourages physician participation. Results will be announced at a press conference in late November.

Provider Tax Reduced to 1/2% August 1

Effective August, 1, 1998, the physician component of the provider tax was reduced to 0.5 (1/2)%. Following a massive public, legal, and legislative campaign by the Kentucky Medical Association, Governor Paul Patton along with Kentucky General Assembly leadership agreed to the gradual repeal of the physician provider tax. The 1996 Kentucky General Assembly ordered the 2% tax to be repealed in components of 1/2%, and phased out completely by August 1, 1999:

August 1, 1996 1.5%
August 1, 1997 1.0%
August 1, 1998 0.5%
August 1, 1999 0.0%

Physicians were paying approximately $44 million at the 2% rate. At a special-called session of the KMA House of Delegates in March 1996, delegates overwhelmingly voted to support Governor Patton's proposal to gradually repeal the tax, restore $52 million in Medicaid funds, increase Medicaid reimbursement to physicians by $26 million annually and repeal onerous sections of the House Bill 250. The KMA had contested the provider tax through the legal system. Even though KMA prevailed in lower courts, the US Supreme Court ultimately denied KMA a hearing thus upholding the Kentucky Supreme Court decision that the tax was constitutional.

1998 OIG Projects

As reported in the July and September 1998 issues of *The Journal*, the Department of Health and Human Services, which oversees the Medicare program, drafts a "work plan" for its Office of Inspector General (OIG). The following are additional excerpts from the work plan that discuss the OIG's emphasis for 1998 on physician services within the Medicare system. The entire report can be obtained from the DHHS website at *http://www.dhhs.gov/progorg/oig.*

- **Billing Services Companies**

This review will determine whether: (1) Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided by beneficiaries; and (2) the agreements between providers and billing service companies meet Medicare criteria. Medicare allows providers to contract with billing service companies that provide billing and payment collection services. The contractual agreement between the provider and the billing service company must meet certain Medicare criteria and a copy of the agreement must be provided to the applicable Medicare carrier. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians. The HCFA officials have expressed concern that the agreements may not meet the required criteria.

- **Improper Billing of Psychiatric Services**

We will determine whether providers are properly billing Medicare for psychiatric services in the following three areas: (1) providers billing Medicare for individual psychotherapy rather than inpatient hospital care, resulting in Medicare overpayments, (2) providers billing Medicare for a psychological testing code on a per test basis rather than a per hour basis, as required, or (3) providers billing Medicare for group psychotherapy in cases which do not qualify for Medicare payment because either the group sessions do not involve actual psychotherapy services or the patients cannot benefit by group psychotherapy. Improper billing of these psychiatric services results in Medicare overpayments.

- **Provider Billing Numbers Issued to Resident Physicians**

We will assess the extent of improper Medicare billings resulting from a control problem we noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities at another institution separate from the institution where the resident is pursuing his/her medical studies. We noted that a hospital in one state requested and received over 40 billing numbers for their residents over a 6 year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. We will determine the extent of this condition at the carrier in this state and other carriers.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Jefferson

Clayton C Barclay MD — EM
14019 Echohill Ln, Louisville, KY 40299
1972, Hahnemann Med Col, Pennsylvania

Daniel Londyn Menkes MD — N
601 S Floyd St Ste 503, Louisville, KY 40202
1988, Boston U

Peter J Urda DO — FP
6503 Mt Batten Ct, Prospect, KY 40059
1978, Col of Osteopathic, Des Moines

Whitley

Nelson F Rodriguez MD — P
100 Jasmine Cir Apt 10, Corbin, KY 40701-1176
1985, U of Santo Tomas, Philippines

IN-TRAINING

Jefferson

Gina Cheryl Hall MD — EM
Mark J McDonald MD — PD

DEATHS

Claude L. McHargue, MD
Monticello
1922-1998

Claude L. McHargue, MD, a retired general practitioner, died August 5, 1998. A 1952 graduate of the University of Louisville School of Medicine, Dr McHargue was a life member of KMA.

George C. Reed, MD
Versailles
1916-1998

George C. Reed, MD, a family practitioner, died August 7, 1998. Dr Reed was a 1941 graduate of the University of Michigan Medical School and a life member of KMA.

Tom J. Smith, MD
Campbellsburg
1907-1998

Tom J. Smith, MD, a retired internist, died August 13, 1998. A 1938 graduate of the University of Cincinnati College of Medicine, Dr Smith was a life member of KMA.

Walter D. Frey, MD
Lexington
1899-1998

Walter D. Frey, MD, a retired ophthalmologist, died August 17, 1998. Dr Frey was a 1929 graduate of Vanderbilt University School of Medicine and a life member of KMA.

John D. Donnelly, MD
Lexington
1941-1998

John D. Donnelly, MD, a urologist, died September 6, 1998. Dr Donnelley was a 1967 graduate of Georgetown University School of Medicine and an active member of KMA.

John M. Allen, MD
Lexington
1927-1998

John M. Allen, MD, a retired general surgeon, died September 8, 1998. A 1954 graduate of the University of Louisville School of Medicine, Dr Allen was a life member of KMA.

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PHYSICIAN'S RECOGNITION AWARDS

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1997 through July 1998.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification — the standard certificate and the PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

Allen
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Mark S. Weis, MD

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Johnny R. Potter, MD

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Robert F. Hendrickson, MD
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Fe L. Bautista, MD

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Hugh K. Dougherty, MD
Lyndon S. Goode, MD
Sean S. May, MD
Don L. Perkins, MD
George R. Valentini, MD
Francis M. Van Meter, MD

Clinton
David C. Chaffin, MD

Crittenden
Howard G. Maddux, MD

Daviess
Garry N. Binegar, MD
Ronald M. Johnson, MD
Robert N. Pope, MD

Fayette
Edwin L. Bunch, MD
Robert J. Bunge, MD
Jitander S. Dudee, MD
Stephen G. Edelstein, MD
Harold T. Faulconer, MD
Michael D. Hagen, MD
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Hopkins
Yhi-Hong Liau, MD
Jerry R. McNeal, MD

Jefferson
Edwin M. Ahrens, MD
Jose S. Bada, MD
Laurie K. Ballew, MD
James W. Bosler, MD
Howard L. Cantor, MD
Stuart P. Cohen, MD
Vernon D. Cook, MD
Richard A. Eiferman, MD
Marjorie Fitzgerald, MD
Martin S. Fox, MD
Linda S. Geis, MD
Herb G. Hay, MD
Pamela M. Hill, MD
Dale S. Horne, MD

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the AMA PRA Certificate with Commendation, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Robert C. Kidd, MD
Robert W. Linker, MD
Steve F. Lipson, MD
Harold J. Livera, MD
Herbert W. Long, MD
Alberto R. Maldonado, MD
Thomas E. McCormick, MD
Sharon A. Merker, MD
Mohammad A. Mian, MD
John D. Rosdeutscher, MD
Thomas M. Roy, MD
Joseph E. Sadtler, MD
Vivek R. Sharma, MD
Daniel C. Sim, MD
Frank G. Simon, MD
Donna J. Smith, MD
Paul A. Spence, MD
James F. Swift, MD
Rebecca A. Terry, MD
Tsu M. Tsai, MD
Robert R. Wahl, MD
Patricia W. Wheeler, MD
Selma P. Winner, MD
George H. Zenger, MD

Kenton
Ralph F. Huller, MD
Robert T. Longshore, MD
Roy J. Moser, MD
James M. Petit, MD
Rhonda R. Pfaff, MD
David W. Suetholz, MD
Henry A. Wells, MD

Lincoln
Linda S. Milholen, MD

Marion
Salem M. George, MD
Brian F. Scott, MD

Mason
Phillip H. Yunker, MD

McCracken
Howard M. Grindlinger, MD
Robert M. Haugh, MD
Kurt Klauburg, MD
Laxmaiah Manchikanti, MD

Nelson
Stanley L. Block, MD

Oldham
Mohammad Shafii, MD

Perry
George R. Chaney, MD

Pike
Baretta R. Casey, MD
William M. Johnson, MD
Mary Lyn Tan Lu, MD
Elvis R. Thompson, MD

Pulaski
Dana L. Gibson, MD

Russell
James E. Monin, MD
M. D. Phelps, MD

Taylor
Eugene H. Shively, MD

Trimble
Winston Y. F. Yap, MD

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Robert J. Emslie, MD

Woodford
Michele M. Welling, MD

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This Fall, the Kentucky Cancer Program is introducing **Providers Practice Prevention**, a **new self-study kit for physicians to increase routine breast and cervical cancer screening** among Kentucky women. The kit includes office reminder systems tools and a video which discusses existing patient barriers, explores screening controversies and provides discussion techniques useful to practitioners as they strive to achieve compliance with patients for cancer screening. The Kentucky Medical Association has been a significant project partner in this project, with two official KMA representatives sitting on the committee and featured in the video.

Participants will be awarded continuing medical education credits and an malpractice insurance premium reduction from the Kentucky Medical Insurance Company and others as designated in the kit. This **free program is funded by the Centers for Disease Control and Prevention through the Kentucky Department for Public Health** and is endorsed by the Kentucky Medical Association, the Kentucky Academy of Family Physicians, UL and UK Schools of Medicine, Kentucky Section-ACOG, the Kentucky Society of Pathologists, the American Cancer Society and other professional organizations.

For more information or to order a kit, **contact the Kentucky Cancer Program: (502) 852-6318 or 1-800-334-8635 ext. 6318.**



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KENTUCKY MEDICAL

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VOLUME 96, NUMBER 12 DECEMBER 1998

SCIENTIFIC	Adnexal Torsion: Endoscopic Management, Case Reports, and Review *Hamid H. Sheikh, MD, FACOG*	**486**
MEDICO-LEGAL	The Latest Word on Confidentiality of Peer Review© *Charles J. "Mike" Cronan, IV*	**491**
EDITORIAL	The Cult of Violence *Jaroslav P. Stulc, MD*	**497**
SPECIAL FEATURES	Delegate Roll Call—1998 House of Delegates	**518**
	Digest of Proceedings—1998 House of Delegates	**521**
	Index to Proceedings and Reports	**522**
	Index to Resolutions	**523**
	Index to *Journal* Volume 96—1998	**571**
	KEMPAC Banquet	**514**
	KMA 1998-99 Organization Chart	**570**
	KMA Reference Committees	**524**
ASSOCIATION	*Monitoring Medicine*	**481**
	Member-Get-a-Member Campaign	**516**
	148th KMA Annual Meeting	**504**
	In Memoriam	**485**
	1998-99 KMA Committees	**567**
DEPARTMENTS	President's Page	**479**
	Advertisers' Guide	**574**
	Alliance Page	**499**
	Information for Authors	**490**



COVER:
This issue of the Journal provides extensive coveroge of the 148th KMA Annuol Meeting, which wos held in Louisville on September 21-24, 1998. An overview begins on page 504, with House of Delegotes coveroge beginning on poge 521.

Cover ort by Lee Wode of Eminence, Kentucky.

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Eventful Years



Donald R. Stephens, MD

1998 has been an eventful year for KMA. We began the year embroiled in another rowdy session of the Kentucky General Assembly, a place where chaos always seems organized. When you participate in this process, it does increase respect for the leadership of the General Assembly. Hindsight tells me that a Session of the KGA may be a "memorable" but "forgettable" experience. The KMA was very successful in its efforts to obtain formidable Patient Protection/Provider Fairness legislation. The General Assembly responded and we are appreciative of their support by enacting House Bill 315. However, on the National level, Congress failed to enact similar protections. Presently, the Federal ERISA statute preemption bars patient protections for approximately 60% of our patients. Nonetheless, managed care, HMOs, and big business, stumbling blocks to patient protection legislation, should be on notice that patients and physicians intend to continue pursuit of this objective. This issue will not go away and support will only increase for its passage. AMA is in the process of obtaining sponsors for similar legislation introduced in 1998, our task is to gain support from the Kentucky Delegation.

Our second major objective in 1998 was to establish a long range planning process for our Association. We accomplished that objective when the 1998 House of Delegates enacted the recommendations, which the Board approved in November. Implementation will be a major objective this year. With "Future Search," we move forward, enhanced with a document that permits us to act or react, either internally or externally, to future objectives, proposals and recommendations. We wrapped up an exciting and eventful year when we joined with the Kentucky Farm Bureau to defeat the proposed Annual Session of the General Assembly Constitutional Amendment.

In the coming year, we look forward to working with members of this Association and others who share our goal of "Patients First." We intend to aggressively pursue support for quality patient care, patient protection, and the principles and goals of this profession. The KMA will be "On the Road in 1998" bringing the Kentucky Medical Association to your town in the form of practice and professional seminars and meetings. Watch for the schedule. In addition, we will be preparing for the 2000 Session and other events as we move to a new millennium.

On behalf of the Board of Trustees and Staff, we extend to you and your family happy holidays and a prosperous New Year. Sonia and I have appreciated your kindness, support, and offers of assistance. We look forward to visiting with you in the coming year, sharing your ideas, and renewing old and making new friends.

Donald R. Stephens, MD
KMA President



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NEWS FOR KENTUCKY PHYSICIANS

Federal Government Issues "Workplan" Detailing Fraud and Abuse Initiatives Aimed at Physicians

The Department of Health and Human Services (DHHS) in Washington is charged with overseeing the federal Medicare program. One branch of DHHS, known as the Office of Inspector General (OIG), investigates and audits whether federal laws and regulations have been followed by participants in the Medicare program. Thus, the OIG investigates physicians and health care providers for alleged fraud and abuse. Each year, the OIG publishes a "work plan" that details what it will be investigating in the area of fraud and abuse for a particular year. What follows are excerpts from that report that detail initiatives aimed at physicians. The new report is similar to the report issued a few months ago, excerpts of which appeared in the *Journal of the Kentucky Medical Association*. The new report, however, mentions new initiatives aimed at physicians, including hospital ownership of physician practices; physician credit balances; billing for services rendered by physician assistants; and, the use of billing service companies. The entire report can be obtained from the DHHS website at http://www.dhhs.gov/progorg/oig.

- ***Outpatient Psychiatric Services***

This review will determine whether psychiatric services rendered on an outpatient basis are billed for and reimbursed in accordance with Medicare regulations. Medicare regulations require that payments be limited to covered services that are supported by medical records. [OIG has] indications from one fiscal intermediary that services rendered in outpatient hospital settings were not documented, not ordered by a physician, nor were covered services. [OIG] will determine if this is also a problem at other fiscal intermediaries.

- ***Duplicate Billing of Outpatient Hospital Services***

[OIG] will compare the billing practices of hospital-based outpatient clinics and physicians who bill for similar services in the clinics. Services rendered in a hospital-based outpatient clinic are billed under Medicare Part B but through a fiscal intermediary. The physicians providing services in these clinics may be billing for the same services under Part B, but submitting their claims to the carrier. If both are billing for and receiving reimbursement for the same services, then duplicate payments result. These types of duplicate payments would be hard to routinely detect because bills are sent to different contractors.

- ***Physician Case Management Billings***

This review will determine if, when a home health claim has been denied by the regional home health intermediary, the Part B carrier also denies any related payments submitted by the physician for oversight of the plan of care. Payment to physicians for plan care oversight is to be recovered when a claim did not meet Medicare criteria for home health services. The intermediaries and carriers should be interacting with regard to such claims. Based on OIG's early survey work, physician billings for plan care oversight could be substantially reduced based on the potential denial rate that should have taken place.

- ***Physicians with Excessive Nursing Home Visits***

[OIG] will identify and audit physicians with excessive visits to Medicare patients in skilled nursing facilities (SNF). The OIG nursing home project identified trends in Medicare and Medicaid payments and populations and identified aberrant providers of nursing home services by type of service. Using this data as well as other computer screening techniques, [OIG] identified physicians with aberrant billing patterns for visits to SNF patients, such as an excessive number of visits in a given day and excessive visits to the same beneficiaries. Individual reviews will be conducted for those physicians with the most egregious billing

patterns. [OIG] also plan[s] to determine how the carriers could better identify and prevent such billings.

- ***Physicians at Teaching Hospitals (PATH)***

This initiative is designed to verify compliance with the Medicare rules governing payment for physician services provided in the teaching setting, and to ensure that claims accurately reflect the level of service provided to the patient. The PATH initiative has been undertaken as a result of the OIG's audit work in this area which suggested that many providers were not in compliance with the applicable Medicare reimbursement policies.

- ***Physician Perspectives on Medicare HMOs***

This study will determine the experiences and perspectives of physicians who work with Medicare health maintenance organizations (HMOs). The OIG has issued numerous reports on Medicare HMOs over the past several years. Some of these reports have raised concerns with the impact of HMOs on the access and quality of health care provided to Medicare beneficiaries. These previous studies have surveyed only Medicare HMO enrollees and administrators. This study will obtain the perspectives of another important player in the Medicare HMO industry, the physician.

- ***Physician Certification of Durable Medical Equipment***

This study will assess how effectively physicians are meeting Medicare expectations that they act as controls against unnecessary use of non-physician services and supplies. This study will build on [OIG] work assessing the physician's role in home health (OEI-02-94-00170) and in completing certificates of medical necessity (OEI-03-96-00010). [OIG] will identify common obstacles and successes in ensuring that physicians perform this important service.

- ***Hospital Ownership of Physician Practices***

[OIG] will assess Medicare billing practices and utilization when hospitals own physician practices. In recent years, integration in the health care marketplace has included hospital purchases of physician practices. Vulnerabilities may include inappropriate referrals (in either direction) between hospitals and physicians, excessive costs and billings, and overutilization of services when hospitals bill the Medicare program through physician practices they own.

- ***Accuracy of and Carrier Monitoring of Physician Visit Coding***

[OIG] will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for evaluation and management services. Generally, the codes represent type and complexity of services provided, and patient status, such as new or established. Previous work by the OIG has found that physicians are not accurately or uniformly using visit codes. This analysis will build upon this previous work and add more definitive data regarding the accuracy of physician visit coding.

- ***Use of Surgical Modifier***

[OIG] will determine whether physicians are improperly using modifier 25 on their Medicare Part B claims to increase reimbursements. Modifier 25 is for physicians to claim "Significant, Separately Identifiable Evaluation and Management Service on the Day of Surgery"—the key words being "Separately Identifiable."

- ***Physician and Other Service Provider Use of Diagnosis Codes***

This review will examine a sample of services paid by Medicare. By comparing Medicare claims to beneficiary medical records, a medical reviewer will determine the extent to which diagnosis codes on claims match the reason for ordering and providing various services. In a previous report entitled "Imaging Services for Nursing Facility Patients: Medical Necessity and Quality of Care" (OEI-09-95-00092), [OIG] found that physicians and other providers of imaging services do not follow HCFA's guidance on use of diagnosis codes.

- ***Physician Credit Balances***

This review will determine whether physicians are reviewing their records for Medicare credit balances and refunding to their carriers those indicating an overpayment. A credit balance occurs when a provider receives and records higher reimbursement than the amount actually charged to a specific Medicare beneficiary. Some credit balances result from duplicate payments and in these cases a Medicare overpayment exists. Past OIG work which identified credit balances at hospitals resulted in significant recoveries for the Medicare program.

- ***Multiple Discharges***

[OIG] will determine whether duplicate payments have been made for day of discharge patient management services. Discharge day management can only be billed by the admitting physician. In one state, [OIG] noted examples where two or more physicians are billing for discharge day management for the same beneficiary admission. [OIG] will develop a computer application to identify those beneficiaries whose discharge day management was billed by more than one physician during a single inpatient stay.

- ***Anesthesia Services***

This review will identify anesthesiologists who bill for personally performed services and determine if these services were in compliance with Medicare regulations. [OIG] found several instances where anesthesiologists were improperly billing for supervising residents in three or more operating rooms at the same time.

- ***Critical Care Services***

This review will focus on those providers who incorrectly bill Medicare for critical care based on the location of the patient and not the actual services provided by the physician. Critical care is that requiring the constant attention of the physician. It is usually, but not always, provided in a critical care area, such as a coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Physician services for patients who are not critically ill but happen to be in a critical care unit are to be claimed using "subsequent care" hospital codes.

- ***Billing for Services Rendered by Physician Assistants***

[OIG] will determine whether physicians are improperly billing for services rendered by physician assistants. Medicare allows physician assistants to render certain services as "incident to" services, which are billed by the employing physician as if the service was personally rendered by the physician. However, if the services do not fall under the "incident to" criteria, the employing physician must bill using a modifier which reduces the Medicare payment. Medicare is overpaying physicians who improperly bill physician assistant services as "incident to" rather than using the proper modifiers.

- ***Billing Service Companies***

This review will determine whether: (1) Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided to beneficiaries; and (2) the agreements between providers and billing service companies meet Medicare criteria. Medicare allows providers to contract with billing service companies that provide billing and payment collection services. The contractual agreements between the provider and the billing service company must meet certain Medicare criteria and a copy of the agreement must be provided to the applicable Medicare Carrier. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians. The HCFA officials have expressed concern that the agreements may not meet the required criteria.

- ***Improper Billing of Psychiatric Services***

[OIG] will determine whether providers are properly billing Medicare for psychiatric services in the following three areas: (1) providers' billing Medicare for individual psychotherapy rather than inpatient hospital care, resulting in Medicare overpayments, (2) providers' billing Medicare for a psychological testing code on a per test basis rather than a per hour basis, as required, or (3) providers' billing Medicare for group psychotherapy in cases which do not qualify for Medicare payment because either the group sessions do not involve actual psychotherapy services or the patients cannot benefit by group psychotherapy. Improper billing of these psychiatric services results in Medicare overpayments.

- ***Physician Incentive Plans in Managed Care Contracts***

[OIG] will review physician incentive plans that are included in contracts that physicians enter into with managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on the utilization levels. It also requires plans to disclose these arrangements to beneficiaries. As part of this review, [OIG] will also look at other clauses in these contracts that may impact the quality of care provided.

- ***Provider Billing Numbers Issued to Resident Physicians***

[OIG] will assess the extent of improper Medicare billings resulting from a control problem [OIG] noted at one carrier relative to issuing provider billing numbers to resident physicians at teaching hospitals. In general, Medicare regulations do not allow residents to bill Medicare for their services. The exception is if the billable services are related to "moonlighting" activities at another institution separate from the institution where the resident is pursuing his/her medical studies. [OIG] noted that a hospital in one state requested and received over 40 billing numbers for their residents over a 6 year period. The residents were not involved in "moonlighting" activities, and the hospital used the numbers to improperly bill Medicare for services provided by the residents. [OIG] will determine the extent of this condition at the carrier in this state and other carriers.

- ***Physician Referrals to Self-Owned Laboratory Services***

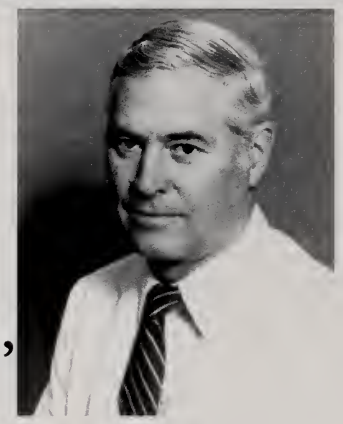
This review will analyze HCFA's enforcement of the self-referral prohibition involving physicians and clinical laboratory services. Medicare law prohibits payment to physicians who have certain proscribed financial relationships with other providers, including entities that provide clinical laboratory services. Other penalties may also apply for violations of this law. [OIG] will analyze whether HCFA has adequate information (ie, ownership and compensation data) to enforce the law with respect to clinical laboratory services, and document the actions taken to date.

- ***Medicare Part B Billings by State Owned Facilities***

This review will use computer screens, developed by the OIG, to identify physicians with aberrant billing patterns for visits to patients in state-owned facilities. Prior focused medical reviews by Medicare contractors identified a variety of problems associated with these types of claims related to skilled nursing facilities. [OIG] will build on this prior work and determine if all types of state-owned facilities have similar problems.

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Adnexal Torsion:
Endoscopic Management, Case Reports, and Review

Hamid H. Sheikh, MD, FACOG

Endoscopy is extremely useful in diagnosing the relatively rare condition of adnexal torsion. The laparoscope can be used to treat this condition by detorsion or excision of the adnexa depending on the stage of ischemia. It can also be used to prevent recurrent torsion or torsion-prone adnexa, by duplication of the ligaments or plication to supporting structures or pelvic wall. Three cases of spontaneous torsion are discussed. Different mechanisms of torsion, pathogenesis, and management are reviewed.

dnexal torsion is a relatively uncommon gynecological condition. It can involve the whole adnexa,[1-7] parovarian cysts, a normal ovary,[8] cystic ovary,[9,10] or fallopian tube[11-17] in the presence or absence of pathology. Torsion occurs most commonly during the reproductive years.[10,18,20] However, it has been reported in children[21-25] and post-menopausal patients.[11] Endoscopy is very useful in early diagnosis and management, and in preserving or excising the adnexa.[5,26,27,28] Ultrasound has a rather limited role in the diagnosis while doppler studies are more helpful in diagnosis of torsion as well as prognosis after detorsion.[5] Three cases are presented: torsion of the adnexa associated with ovarian cyst, torsion of a parovarian cyst, and torsion involving a diseased fallopian tube.

Case Reports

1. A 21-year-old G-0 was referred from an outlying hospital with increasing pelvic pain for about 12 days. An ultrasonographic examination had revealed a right ovarian cyst (4 × 4 cm) and cul-de-sac fluid. A pregnancy test was negative. On admission, she had a temperature of 100°F and a blood pressure of 98/72. Bimanual examination was difficult due to severe tenderness, and the white blood cell count was 11,700. Laparoscopic examination revealed a non-salvageable adnexa with torsion at the pedicle. Serosanguineous fluid was present in the pelvis. A gangrenous, edematous, and friable adnexa measuring 12 cm × 10 cm was excised. The excision was carried out through a mini laparotomy suprapubic incision due to the size of the mass. The peritoneal cavity was irrigated with Ringer's Lactate solution, and perioperative antibiotics were given. She was discharged home after 24 hours. (Figure 1)

2. A 41-year-old patient had initially been taken care of in the emergency room of a hospital for acute pelvic pain and referred with a diagnosis of a cyst of the ovary. The laboratory data was entirely within normal limits. Laparoscopic exploration subsequently revealed torsion of a parovarian cyst, which was simply excised through the laparoscope without further treatment. The patient was discharged home the same day. (Figure 2)

3. A 23-year-old patient was seen for chronic pelvic pain which had suddenly changed in severity. No significant abnormalities were noted in the laboratory data and torsion was not considered in the differential diagnosis. Laparoscopic exploration revealed a left hydrosalpinx with torsion at the base. Aspiration of the contents of the hydrosalpinx was carried out before the tube was resected laparoscopically. The peritoneal cavity was irrigated and prophylactic antibiotics given. The patient was discharged home the same day. (Figure 3)

Discussion

Diagnosis of adnexal torsion preoperatively is relatively difficult. Pelvic inflammatory disease, endometriosis, urinary tract infection, Mittelschmerz phenomenon, acute appendicitis, ruptured ovarian cyst, ectopic pregnancy, diverticulitis, and degeneration of leiomyomata are included in the differential diagnosis.[1,4] Recurrent torsion which detorses spontaneously is definitely a diagnostic challenge.[18] In most cases torsion is unilateral, but rarely can be bilateral.[29] Since Sutton described the first case of torsion in 1890, several

hundred cases have been reported.[30] Cases of torsion of the fallopian tube with and without pathology have also been published.[11-17,32] Torsion of the adnexa in pregnancy occurs more commonly in early pregnancy[9,27,31] than in the third trimester.[32] Ectopic pregnancy is probably associated with torsion more frequently than has been reported. Formerly, without the use of endoscopy, diagnosis was usually delayed. In such cases, perhaps the adnexa amputated spontaneously and became fibrotic or calcified in an unidentifiable structure,[33-35] referred to as the "Absent Adnexa Syndrome." Furthermore, a number of cases of torsion of the adnexa after various surgical procedures have been reported, as after resection of ectopic pregnancy,[13] in association with a defect in the mesosalpinx,[36] after laparoscopic sterilization,[4] or after partial salpingectomy-type sterilization.[6] Interestingly, since assisted reproduction has been pursued aggressively with superovulation, the incidence of adnexal torsion has increased.[5,10,19,20] Approximately one third of the reported cases have been diagnosed preoperatively, and half of these were without any observed predisposing cause.[4]

Pathogenesis of Adnexal Torsion

Torsion can be due to weakness in the supporting structures of the adnexa, a pendulum effect of heavy ovaries or tubes (normal or due to pathological conditions) or due to the presence of intra or extra pelvic tumors or enlarged organs, which may torse the adnexa with positional changes and fix it in a torsioned position.[4,5]

Predisposing Factors

Ovarian factors include ovarian ectopic pregnancy, adenomas, cystomas, fibromas, endometriomas, dysgerminomas, and dermoids or hyper-stimulation of the ovaries, either exogenous from ovulation[39,40,41,42] or endogenous from polycystic ovaries. A large corpus luteum due to multiple pregnancies and omento-ovarian adhesions can predispose to torsion.

Tubal factors can be congenital such as long tubes, absent mesosalpinx, weakness or a defect in the mesosalpinx, iatrogenic from excessive excision or cauterization of tubes during sterilization,[4,5,37,38] or pathological such as hydrosalpinx, ectopic tubal pregnancy, and paratubal cysts.

Adjacent intrapelvic organs may cause torsion as in the case of a pregnant uterus, leiomyo-

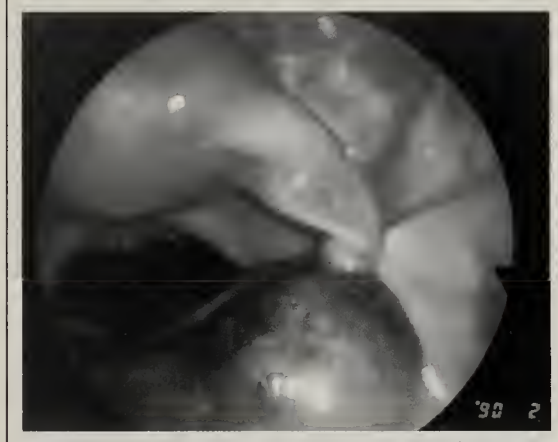


Figure 1 — Uterus, tube, utero-ovarian ligament, torsioned gangrenous adnexa, and dark fluid in the culdesac are visible on the right side of the patient. The adnexa consists of tube, ovary, a cyst and the direction of torsion is counter clockwise.

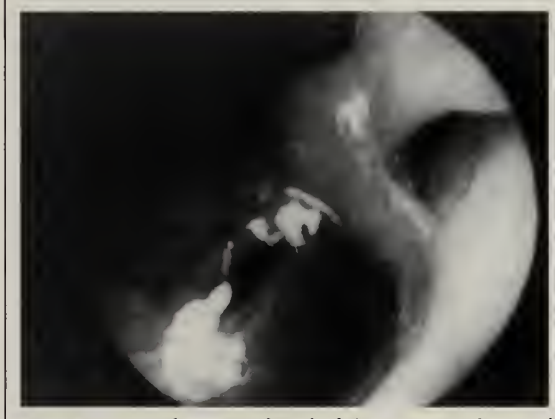


Figure 2 — Right cornual end of the uterus, tube, and torsioned paraovarian cyst are visible.

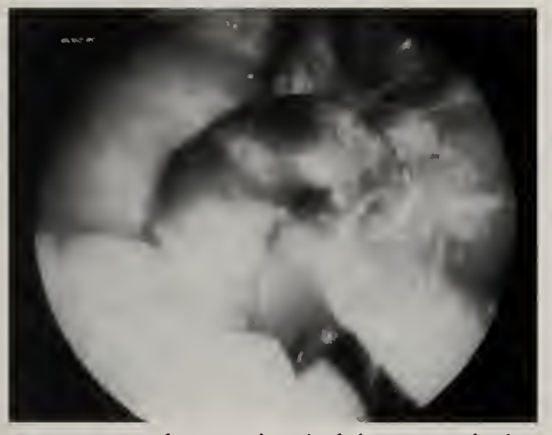


Figure 3 — Left cornual end of the uterus, hydrosalpinxed tube twisted on itself is visible. The torsion is clockwise.

matous uterus, an intra-abdominal mass, or organomegaly.[1]

Mechanism of Torsion

Spontaneous occurrence of torsion without any predisposing factors may be caused by an episode of tubal spasm, or other physiological disturbances of tubal motility. It can also be the result of excessive tortuosity of engorged veins of the mesosalpinx as during pregnancy.

Sudden changes in body motion or body position as occur in automobile accidents, certain exercises, or sexual intercourse may cause rotational displacement of adnexal structures resulting in torsion.[1,48]

Pathological Changes

Torsion can be either complete or incomplete and acute, chronic, or recurrent. In the case of chronic, recurrent, and incomplete torsion, the reversible ischemia will cause congestion, swelling, and minimum extravasation of fluid. Detorsion will return the adnexa to its normal appearance.

In the case of complete and permanent torsion, the adnexa will become edematous with venous engorgement. Extravasation of straw colored fluid in early stages is followed by serosanguineous fluid and finally a friable, blue black, infarcted, gangrenous, and dead adnexa.[5]

Clinical Features

The patient may present with sudden onset of one sided or bilateral sharp or dull pain,[4] which can be recurrent with spontaneous periods of relief.[18] There may be a minimum increase in white cell count or a low grade fever.[4] In early stages, unless the pre-existing cause is a cyst or a pelvic or adnexal tumor, no mass may be felt on bimanual examination or seen on sonographic examination.[5] Abdominal distension and diffuse tenderness may be present in advanced cases[4,25] with accompanying symptoms of nausea, vomiting, weakness, low grade fever, or diarrhea.[4,43]

Differentiation from other conditions like endometriosis, urinary tract infection, chronic or acute pelvic inflammatory disease, Mittelschmerz phenomenon, rupture of a cyst, ectopic pregnancy, or diverticulitis is difficult. In cases of torsion of the right adnexa, differentiation from acute appendicitis can be a challenge.[4,9] Torsion of a hyperstimulated cystic ovary must be considered when evaluating a patient with acute pelvic pain who is undergoing ovulation induction for assisted reproduction.[10,19,20]

The Role of Endoscopy

Before the introduction of the laparoscope, diagnosis of torsion was usually made at the time of laparotomy by which time the adnexa would usually be found to be gangrenous. Therefore, even with a minimum index of suspicion, particularly if predisposing factors are present, urgent use of the laparoscope can save an adnexa. This approach may result in an unnecessary procedure, but saving the adnexa in previously infertile patients (in whom ovarian stimulation has been carried out), far outweighs a few negative laparoscopic explorations.[5,18,20,24,26-28]

Management

After establishing the diagnosis with the aid of the laparoscope, the treatment depends on the type and appearance of the torsed adnexa. Recurrent and incomplete torsion can be treated by detorsion and observing for return of viability. At the same time, the predisposing cause of torsion is corrected. Plication of the torsion prone adnexa to the pelvic wall or to supporting structures and strengthening of weak or loose supporting ligaments can prevent future torsion.[5,15,28,46] In advanced cases where the diagnosis is delayed, a friable infarcted, gangrenous adnexa will be seen. In this instance, detorsion of the adnexa may arguably not be advisable because of the theoretical possibility of dislodging emboli.[1,49] The operative technique for excision of such an adnexa depends on its size and the surgeon's choice.[5,28]

In cases where preservation of the adnexa is of utmost importance in infertility patients, or where viability is in question, attempts to detorse the adnexa should be conducted followed by close observation. In such cases, heparinization is advisable.[28] Doppler scanning for evidence of revascularization and viability, if available, can be included in management. Repeat laparoscopic exploration should be carried out in 24 hours or depending on the clinical condition of the patient. Not infrequently, marginally viable adnexae have been found to be salvaged and functioning normally in the course of time.[5] Knowledge of the direction of the torsion (Kustner's Law) is important because, if the condition is advanced, swelling will make it difficult to ascertain the direction of tor-

sion.[47] Surgical manipulation may further torse an already compromised adnexa and predispose it to infarction, more so with a laparoscopic approach.[4,5]

Conclusion

Timely and appropriate use of laparoscopy is essential in the diagnosis and treatment of adnexal torsion. Ultrasound has a limited value in the diagnosis of torsion. Doppler studies are helpful for prognostic evaluation after detorsion. Adnexal torsion may be included in the differential diagnosis of acute pelvic pain, especially if predisposing factors are present.

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References

1. Nicols DH, Julian PJ. Torsion of the adnexa. *Clin Obstet Gynecol.* 1985;28:375-380.
2. Hibbard IT. Adnexal torsion. *Am J Obstet Gynecol.* 1985; 152:456-461.
3. Lomano JM, Trelford JD, Ullery JC. Torsion of the uterine adnexa and causing an acute abdomen. *Obstet Gynecol.* 1970; 35:221-225.
4. Sheikh HH. Adnexal torsion and gangrene following sterilization. *The Female Patient.* 1986;11:40-45.
5. Sheikh HH. Adnexal torsion, the role of endoscopy, case reports and review. Proceedings of the world congress of gynecologic endoscopy. Jerusalem. Feb 26-March 3, 1995.
6. Chatham ST. Adnexal torsion following sterilization, letters to editor. *The Female Patient.* 1986;11:22.
7. Warmick L. Trois cas de tumeurs des trompes compliquees de la torsion du pedicle. *N Arch D'Obstet De Gynecol.* 1895; 10:81-84.
8. Baron D. Torsion of normal ovary. *JAMA.* 1934;102:1675-1677.
9. Kikozka J, Budynska DW. Pregnancy complicated by torsion of an ovarian cyst and gangrenous appendicitis. *Pol Tyg Lek.* 1973;28:2023-2027.
10. Chin NW, Friedman CI, Awadalla SG, et al. Adnexal torsion as a complication of superovulation for ovum retrieval. *Fertil Steril.* 1987;48:149-151.
11. Powell JL, Foleuy FP, Liorens AS. Torsion of the fallopian tube in post menopausal women. *Am J Obstet Gynecol.* 1972; 113:115-117.
12. Bernades RE, Vander Slikke JW, Roexx AJM, et al. Torsion of the fallopian tube: some consideration of its etiology. *Obstet Gynecol.* 1984;64:673-677.
13. Demir RH, Madanes AE. Torsion of a fallopian tube remnant years after conservative segmental resection for ectopic pregnancy, a case report. *Am J Gynecol Health.* 1989;3:124-125.
14. Maynard RS, Peipert FJ, Brody MJ. Tubal torsion appearing as acute pelvic inflammatory disease. *J AAGL.* 1996;3:431-433.
15. Youssef AF, Favad MM, Shafeek MA. Torsion of fallopian tube, a clinico pathologic study. *Acta Obstet Gynecol Scand.* 1962;41:292-296.
16. Filtenborg TA, Hertz JB. Case report torsion of fallopian tube. *Eur J Obstet Gynecol Reprod Bio.* 1981;12:177.
17. Provost RW. Torsion of the normal fallopian tube. *Obstet Gynecol.* 1972;39:80-83.
18. Sheikh HH. Recurrent adnexal torsion and cystadenoma of aberrant ovarian tissue. *South Med J.* 1991;84:1037-1038.
19. Kemmann E, Ghazi DM, Corson GH. Adnexal torsion in menotropin induced pregnancies. *Obstet Gynecol.* 1990;76:403-405.
20. Hurvitz A, Milwidsky A, Yagel S, et al. Early unwinding of torsion of an ovarian cyst as a result of hyperstimulation syndrome. *Fertil Steril.* 1983;40:393-394.
21. James DF, Barber HR, Graber EA. Torsion of uterine adnexa in children: report of 3 cases. *Obstet Gynecol.* 1970;35:226-231.
22. Ladnia IS. Gangrene of a twisted ovary in girls. *Khirurgia [Mosk].* 1972;48:119-122.
23. Bower RJ, Adkins JC. Surgical ovarian lesions in children. *Am Surg.* 1981;47:474-479.
24. Shlave E, Mann S, Romano S, Rahav D. Laproscopic detorsion of adnexa in children: a case report. *J Pediatr Surg.* 1991; 26:1193-1194.
25. Farrel TP, Boal DK, Teele RI. Acute torsion of normal uterine adnexa in children. Sonographic demonstration. *AJR.* 1982; 139:1223-1226.
26. Shalav E, Peleg D. Laproscopic treatment of adnexal torsion. *Surg Gynecol Obstet.* (USA) 1993;176:448-450.
27. Shalv E, Rahav D, Romano S. Laproscopic relief of adnexal torsion in early pregnancy: Case reports. *Br J Obstet Gynecol.* 1990;97:853-854.
28. Mage G, Canis M, Manhes H, Pouly JL, Bruhat MA. Laproscopic management of adnexal torsion, a review of 35 cases. *J Reprod Med.* 1989;34:520-524.
29. Dunnihoo DR, Wolf J. Bilateral torsion of the adnexa: a case report and review of the world literature. *Obstet Gynecol.* 1984;64:555-560.
30. Sutton JB. Salpingitis and some of its effects. *Lancet.* 1890; 2:1146-1151.
31. Garzarelli S, Mazuca N. One laparoscopic puncture for treatment of ovarian cysts with adnexal torsion in early pregnancy. A report of two cases. *J Reprod Med.* 1994;39:985-986.
32. Kliment I, Gottwald Z. Torsion and gangrene of the right fallopian tube in the third trimester of pregnancy. *Cesk Gynecol.* 1975;40:673-677.
33. Beyth Y, Aron E. Tubo ovarian autoamputation and infertility. *Fertil Steril.* 1984;42:932-936.
34. Sebastian JA, Baker RL, Cordrey F. Asymptomatic infarction and separation of ovary and distal uterine tube. *Obstet Gynecol.* 1973;41:531-535.
35. Silva PD, Glasser K, Virata R. Spontaneously acquired, unilateral absence of the adnexa, a case report. *J Reprod Med.* 1995;40:63-64.
36. Kyosol K. Simultaneous occurrence of ovarian torsion and gangrene strangulation through a congenital opening in the mesosalpinx. *Am J Obstet Gynecol.* 1977;66:290-292.
37. Sheikh HH. Hysterosalpingographic follow up of laparoscopic sterilization. *Am J Obstet Gynecol.* 1976;126:181-185.
38. Sheikh HH. Hysterosalpingographic follow up of partial salpingectomy type sterilization. *Am J Obstet Gynecol.* 1977; 128:858-861.
39. Lee RA, Baron E. Tubo ovarian auto amputation and infertility. *Fertil Steril.* 1984;42:932-938.
40. Moravec WD, Angermann NS, Reale FR, et al. Torsion of the uterine adnexa: a clinicopathologic correlation. *Int J Gynaecol Obstet.* 1988;18:7-12.
41. Azoury RS, Chemab RM, Muffarrij IK. The twisted adnexa: a clinical pathological review. *Diagn Gynecol Obstet.* 1980;2:185-194.
42. Mcgowan L. Torsion of cystic or diseased adnexal tissue.

Am J Obstet Gynec. 1964;88:135-141.
43. Baker TE, Copas PR. Adnexal Torsion: A clinical dilemma. *J Reprod Med.* 1995;40:447-449.
44. Woodruff JD, Paurstein CJ. *The Fallopian Tube.* Baltimore: Williams and Wilkins; 1969:254.
45. Grivas T, Greene R, Banos P, et al. Isolated torsion of the fallopian tube, an important differential diagnosis to acute abdominal pain. *The Female Patient.* 1996;21:95-96.
46. Germain M, Rarick T, Robins E. Management of intermittent ovarian torsion by laparoscopic oophoropexy. *Obstet Gynecol.* 1996;88:715-717.
47. Kustner O. Das Gesetzmalsige in der Torsionsspirale torquirter Ovarialtumorstiele. *Zentralbl Gynecol.* 1891;15:209-213.
48. Bernardus RE, Van Der Slikke JW, Roex AJM, et al. Torsion of the fallopian tube: Some consideration on its etiology. *Obstet Gynecol.* 1984;64:675-680.
49. Bider D, Ben-Rafael Z, Goldenberg M, Shalev J, Mashiach S. Pregnancy outcome after unwinding of twisted ischaemic-hemorrhagic adnexa. *Br J Obstet Gynaecol.* 1989;96:428-430.

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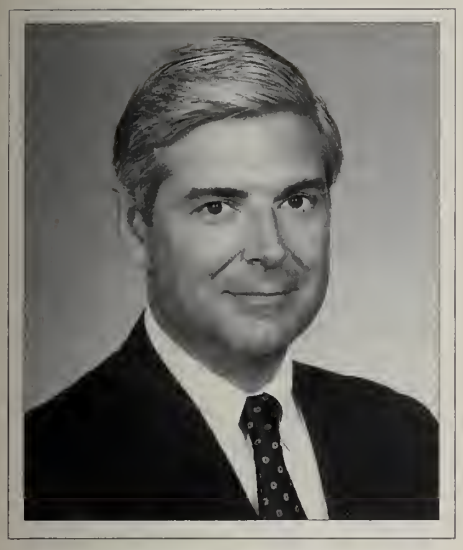
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Charles J. "Mike" Cronan IV

The Latest Word on Confidentiality of Peer Review©

The Kentucky Supreme Court has spoken the latest, but unlikely to be the last word in the battle between the Court and the Kentucky General Assembly, on the issue of whether peer review records are subject to discovery in a medical malpractice lawsuit. In *Sisters of Charity Health-Systems, Inc, d/b/a Flaget Memorial Hospital v Larry D. Raikes, Judge, Nelson Circuit Court, et al*, a five to two opinion published by the Court on September 3, 1998, the Kentucky Supreme Court held that peer review documents are discoverable in medical malpractice suits. As a result, writes the Court, "peer review participants have no present, valid expectation that their input into peer review proceedings will be shielded from discovery in a medical malpractice suit." The news, however, is not all bad because the opinion also strongly reaffirms the immunity from damage claims by aggrieved physicians against those physicians who conduct or participate in good faith peer review. This article summarizes important points from the opinion and offers some practical observations and suggestions for protecting the peer review process and peer reviewers.

The "Peer Review Confidentiality" Statute

In fact, what is often referred to as the "peer review confidentiality" statute addresses several other subjects which are important to an understanding of the Kentucky Supreme Court's recent opinion. The relevant statute, KRS 311.377, actually contains eight subsections, the first five of which are most important here. They are summarized as follows:

(1) "Any person who applies for, or is granted, medical staff privileges, . . . shall be deemed to have waived . . . any claim for damages or any good faith action taken by any person who is a member, participant in or employee of, or who furnishes information, professional counsel, or services to any committee, board, commission or other entity . . . performing the designated function of review of credentials or retrospective review and evaluation of the competency of professional acts or conduct of other healthcare personnel."

(2) ". . . the proceedings, records, opinions, conclusions and recommendations of any committee, board, commission, medical staff, professional standards review organization, or other entity, as referred to in subsection (1) . . . shall be confidential and privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil action in any court . . ."

(3) "Nothing in subsection (2) . . . shall be construed to restrict or limit the right to discover or use in any civil action . . . any evidence, document or record which is subject to discovery independently of the proceedings of the entity to which subsection (1) . . . refers."

(4) "No person who presents or offers evidence in proceedings described in subsection (2) . . . or who is a member of any entity before which such evidence is presented . . . may refuse to testify in discovery or upon a trial of any civil action as to any evidence, document or record

described in subsection (3) . . . or as to any information within his own knowledge except as provided in subsection (5)..."

(5) "No person shall be permitted or compelled to testify concerning his testimony or the testimony of others except that of a defendant given in any proceeding referred to in subsection (2) . . . or as to any of his opinions formed as a result of such proceeding."

Background of the Case

The Court's opinion actually applied to three separate cases in which trial court judges issued orders compelling the disclosure of peer review records in medical malpractice lawsuits. A good bit of the opinion deals with procedural matters which will not be discussed in this article. Although the majority acknowledges numerous attempts by the Kentucky General Assembly to reenact the confidentiality statute after previous decisions of the Court, the opinion, and now the controlling law, concluded that peer review material is now discoverable in medical malpractice suits. In reaching that result the Court also observed that, "Peer review participants have no present, valid expectation that their input into peer review proceedings will be shielded from discovery in a medical malpractice suit."

In a strongly worded dissent, Chief Justice Stephens observed that it is the duty of the General Assembly to determine the public policy of the Commonwealth and to enact legislation in conformity with it. It is the duty of the Court to interpret the legislation in light of principles of statutory interpretation but in accordance with public policy as expressed by the General Assembly. Cautioning the majority members, Chief Justice Stephens wrote, "Whether KRS 311.377(2) is 'fair' or 'reasonable' is a matter for the citizens of the Commonwealth to determine through their elected representatives. We are not a superlegislature and should not act as such." He then concluded that, when the General Assembly wrote the words that peer review documents were not subject to discovery "in any civil action," it intended the law to extend to medical malpractice lawsuits.

Effect on Peer Reviewers' Immunity from Liability for Damages

In the process of explaining its rationale for limiting the scope of confidentiality to be afforded peer review documents when sought in medical malpractice cases, the Kentucky Supreme Court strongly reemphasized that the main purpose of KRS 311.377 (1) is to protect peer review participants and organizations by conferring immunity, on persons and organizations who conduct good faith peer review, from any claim for damages by a physician who is aggrieved by the peer review process.

Effect on Confidentiality of Peer Review Records

Addressing subsection (2) of the statute and the privileged and confidential nature of peer review documents, the Court concluded that the privilege conferred by subsection (2) must be limited in scope to the immunity afforded to peer reviewers by subsection (1) of the statute. As a result, the Court concluded that the confidentiality afforded peer review documents by subsection (2) was intended by the legislature to extend only to litigation or administrative proceedings by an aggrieved physician against peer reviewers. Thus, subsection (2) does continue to have some meaning and effect, but only as it pertains to lawsuits by a physician against peer reviewers, not as it pertains to lawsuits against defendants in medical malpractice cases. However, as the Chief Justice pointed out in his dissent, a privilege against disclosing peer review documents in a lawsuit by an aggrieved physician against peer reviewers is of little practical benefit. This is true, because, in most instances, those records confirm that the reviewers acted in good faith and on the basis of substantial facts. Thus, it is often the peer reviewers who choose to introduce these records in such litigation rather than invoke any privilege against their disclosure.

Also as a practical matter, subsections (3) and (4) of the statute already made it clear that no confidentiality or privilege attached to any evidence or document used in a peer review proceeding if that evidence or document was independently discoverable. In other words, a physician's notes in a patient's medical record or an operative report in the medical record did not attain a protected status from discovery in a medical malpractice lawsuit merely because those documents might also have been used during the course of a peer review proceeding. Thus, even before the Court's recent opinion, privilege and confidentiality extended only to such things as the minutes or other documents prepared specifically as a result of the peer review proceeding and not during the ordinary course of patient care.

Effect on Testimony by Peer Reviewers

As noted above in the discussion of subsection (4), a participant in peer review proceedings who had independent knowledge obtained outside the peer review process could not refuse to testify as to that independent knowledge in a medical malpractice case. However, subsection (5) of the statute protects the peer reviewer against being compelled to

testify, in any case, about his own testimony or his opinions formed, or the testimony of others (except a defendant in a malpractice case) during the course of the peer review proceeding. Subsection (5) protection against compelled *testimony* was not the subject of the Court's recent opinion nor was it addressed by the Court. Thus, peer reviewers may continue to invoke protection against being compelled to testify about their own opinions formed or expressed, or the testimony of others (except a defendant) in the conduct of the peer review proceedings. However, if the peer reviewer's statements or opinions are reduced to writing in the minutes of the peer review proceedings, the minutes will be subject to discovery. As a practical matter, the effect of subsection (5) is to protect peer reviewers from the annoyance and inconvenience of being compelled to testify on matters about which they learned only through the peer review process.

Conclusions and Observations

- This opinion only addresses the right of the medical malpractice plaintiff to discover the existence of peer review documents pertaining to a malpractice defendant. Thus, it applies only in a situation where a lawsuit has actually been filed. It does not mean that peer review records must be produced as part of a "fishing expedition" before any lawsuit is filed. It also does not adversely affect any confidentiality otherwise bestowed on peer review documents and proceedings by the medical staff bylaws or by other state or federal laws and regulations. Thus, it is important for hospitals and other peer review organizations to continue with their utmost efforts to preserve the confidentiality of peer review proceedings until they have become the subject of discovery in a malpractice lawsuit.

- The opinion did not discuss whether peer review records made available through discovery in a medical malpractice action can be used for any purposes outside that lawsuit. Accordingly, it is always good practice, before releasing any peer review documents, to seek a protective order from the trial court prohibiting the use or dissemination of the records beyond the lawsuit in which they have been sought.

- The opinion only addresses the discoverability of peer review records. It does not discuss their admissibility in evidence in a malpractice case. Even though the records may be subject to discovery, they must also be shown to be relevant to an issue in the malpractice case before they could be admitted in evidence. Of course, the central issue in a malpractice case is whether the physician's care of the plaintiff adhered to the standard of care of other reasonably prudent physicians under similar circumstances. Because many forms of peer review proceedings (such as credentialing or quality improvement actions) are not intended to determine whether a physician has adhered to the standard of care with a particular patient, it may be helpful to note the purpose of the peer review proceeding on the face of all documents as they are prepared.

- The opinion would not prohibit the party producing the records from doing so "*in camera*"; that is, subject to the court's first looking at them to determine if they are relevant to an issue in the lawsuit. This would be discretionary with the trial court, but would certainly be a legitimate request in appropriate cases.

Summary and Conclusion

The most significant change effected by the Court's opinion is that records and documents developed in, or as a result of, the peer review proceedings are now discoverable in medical malpractice lawsuits. In reaching that conclusion the Court reemphasized that there is immunity from damage claims asserted by aggrieved physicians against peer reviewers for conducting or participating in good faith peer review. The law is unchanged which permits discovery of events and documents which occurred or were prepared *independently* of the peer review proceedings. Also unchanged by the opinion is the protection against a peer reviewer being compelled to testify about his own opinions or testimony, or the testimony of others, in the peer review proceedings.

The majority opinion illustrates a considerable suspicion and lack of understanding about the nature of modern peer review proceedings. As has been the course of conduct over the past 25 years, the next discussion of this subject is likely to occur in the Kentucky General Assembly. In the meantime, it appears that much work needs to be done to assure that both legislators and judges are fully informed about the legitimate problems and public policy issues pertaining to peer review. I would join with the Chief Justice's dissenting opinion that the final word on matters of such public policy should be spoken by the legislature and not by the courts.

Charles J. "Mike" Cronan IV

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Mr Cronan practices law with the firm of Stites & Harbison, 400 W Market St, Louisville, KY. He is General Counsel for the Kentucky Medical Association.

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The Cult of Violence

That autumn morning in rural Iowa was like any other, gray and chilled, as I left first period high school physical education for my next class, barely noticing a thin and bespectacled young boy rush past me. Moments later, three crisp, loud shots rang out behind me in the locker room, leaving a star athlete permanently paralyzed lying on the bloody tile floor. For months before, the athlete had bullied and teased the young boy to the emotional breaking point, until the recent death of the boy's father drove him to desperation. Two young lives were unalterably affected in an instant, yet this tragedy barely made the news, was not debated nor even discussed beyond whispers, for the event was a nonentity, so aberrant an act as to defy ratiocination let alone repetition. That happened 35 years ago. Today, homicide is the second leading cause of death among adolescent males while fatalities from firearms cause more deaths among adolescents than all medical illnesses combined. And though both adult and juvenile crime rates over all have significantly decreased this decade, the number of children and adolescents killed by firearms has increased 153% from 1985 to 1995. Juvenile crime is becoming more violent, murderers are apt to be younger and to preferentially use guns ever more frequently in committing acts of violence.

Violence and murder perpetrated by youth is not a new phenomenon in this or any other civilization. Regarding warfare the most organized form of violence, historically from the Greek Hoplites, Turkish Janissaries and Polish Winged Hussars through to the Grande Armee and Waffen-SS, it has been the youth, almost exclusively males who have conducted the actual acts of violence and atrocity. And from the killing fields of Rwanda to Kosovo, it is often the youth, at times even children who are the killers, though the murderous decrees and bigotry may be passed on down from their elders. Why this should be so remains unresolved—blame it on the perpetuation of killer ape genes, prehistoric ritualization of predator fears, hyperactive testosterone levels, or the disintegration of family and society. The singular commonality is a permissive society and its values that foster and condone, even tacitly, the conduct of violence as a natural and acceptable form of behavior in order to achieve personal, political, or economic aims.

Though there may exist a strong biological predetermination, violent behavior is essentially learned, just as is bigotry, hatred, compassion, and responsibility. Violent behavior of mild and limited nature is commonly observed among the youngest of children, but through socialization and progressive impulse control the child develops morally to understand the relationship of actions and consequences, to appreciate the difference between right and wrong and inculcates societal values. At what age range this occurs is arguable, but certainly part of this process is dependent on role models that act as a guide path towards this development. Traditionally, the family and society have provided those models. Now, however, compelling studies suggest that it is the "non-shared environment" involving peer groups that provide moral and social cues to the child, not the "shared environment" of family, school, or church which determine upon the child the traits of the adult. In other words, parents and authority figures have lost much of their influence in determining the development of the child and adolescent.

As importantly, consideration must be given to the powerful influence in this media age of the entertainment and advertisement industries upon the young, malleable mind. All too often, the patent entertainment formula follows the path of least resistance, appealing to the most common denominator—voyeurism of violence to secure maximal commercial lucre. Efforts to control exposure of children to such portrayals of violence have been largely ineffectual and impossible to regulate or enforce. Images of violence permeate our culture and are exceedingly difficult to avoid, appearing nightly on television screens, in movie theaters, evoked in popular music, and graphically illustrated in comic books and video games. The average child will have witnessed tens of thousands of violent acts and various forms of murder on television and in movies by the time he attains adulthood. Such horrific repetition subliminally endorses, if not glamorizes, violent behavior and, more perniciously, gradually diminishes the power of the imagery to shock and disturb.

Even Spielberg doesn't get it right, nor can anyone in attempting to

portray the true complexion of violence and war: the terror, the nausea, the initial shocks to all the senses, the smell, noise and shabbiness, and the subsequent shame, repugnance, relief, sense of loss and sorrow. Ask any combat vet who's been there, if he'll talk about it, how has he coped with it. Short of injuries or desertion, the only way to persevere and maintain one's sanity in the presence of unrelenting perceived dangers and horrors is to become numb, desensitized, oblivious to your own welfare as well as to the suffering and death of others. This, of course, comes at great cost. Ask the vet from Pelileu, Chosin Reservoir, Da Nang about the vivid flashbacks, chronic anxiety, lack of focus, crying jags, and recurrent nightmares. Now imagine how the young child copes, unable in a world of magical thinking, to discriminate between images on television and reality. Compound the effect daily and ultimately the child becomes desensitized to the violence, potentially unable to appreciate the fine nuances of morality, social values, truth, effects and consequences, and insulated from the ability to empathize with the suffering of others. Violent behavior becomes perceived as an alternative and acceptable recourse for achieving vengeance, respect, another's property, for the settlement of disputes or simply for the primal venting of personal frustrations or need for excitement.

The final component to the equation of violence is the incredible availability to our youth of guns in this country, via the arsenals accumulated by some families and neighbors or through "strawmen," adults who procure firearms as middlemen to sell illegally on the streets to youngsters. Thus, the inherent incentives in troubled, restless youth combined with a construed cult of violence multiplied by the ready access to guns equates to increased violence in homes, schools, and streets by younger, more violent and better armed offenders. It has been said that society is akin to a three-legged stool, the legs being family, school, and church; without support from any one of these, the stool will collapse. To many of our young, those supports have become irrelevant, the societal and moral cues coming instead from their peers and from the entertainment media in a culture glutted with imagery of violence and glorification of the gun.

I have received expert marksman medals in the Navy in pistol and rifle; I have proudly served with the Marine 134th Regiment, having assaulted berms in combat drills with live rounds and tracers ricocheting off rocks around me. I have had lessons in the combat handgun and tactical shotgun. Guns frighten me. As a trauma surgeon, I have observed and managed the results of violent assault on the human body, seen the effects of firearms on virtually every portion of the human anatomy, seen young people die, counseled grieving friends and family. Violence frightens me. Violence is the most perverse, obscene of human behaviors, the ultimate pornography. Yet, this fascination with it permeates our lives. As physicians, we need to address this malady in our culture, which is as deadly as any disease. And if not as physicians, then as citizens and as parents. And if we do not, who will? This society frightens me.

Jaroslav P. Stulc, MD

A Holiday Gift of Special Memories to the KMA



Jan Crase

When one has a cherished home, a cherished family, and cherished friends, that home, family, and friends abide with us always—at least in the heart. The yearning to stand where we once stood and to feel as we once felt sometimes calls us like a Mother's voice. During the Holiday Season these cherished memories seem especially poignant. One's personal reminiscence and heritage are treasures that are too often unappreciated.

We may think our personal history or heritage is significant only to us, but will it be meaningful to our descendants? Will it be of interest to colleagues or possibly others? What will be your legacy? It may not be as significant as Ephriam McDowell and the preservation of the McDowell House, but each has his or her own story that will probably be meaningful to some descendant at some time in the future; therefore, it is worth preserving. The McDowell House and Dr McDowell's story continue to be preserved with the support of the KMA and the Alliance.

The interesting stories written in the "MediScope" by Glen Bastin about outstanding physicians in Kentucky has been a popular item with both physicians and patients. One such story about Dr Louise Hutchins was an inspiration to the KMA Alliance to further preserve her significant contribution by producing a documentary video about her work. Upon reading Mr Bastin's story and learning of a grant available from Southern Medical Association Auxiliary, the Alliance decided to seek further funding and produce a video preserving a small portion of the history of this doctor's unique contribution to the health and welfare of people in this Commonwealth.

The video, titled "Dr. Louise Hutchins, Medical Pioneer—Three Decades of Family Planning in Appalachia," was produced with the help of Kentucky Education Television, Ernie Martin, Berea College, Shannon Wilson (Berea College Archivist), a grant from Southern Medical Association Auxiliary, and funding from Ortho McNeil Pharmaceutical under the direction of the Alliance. By forming these coalitions with others for funding and research, the project became a reality and this bit of medical heritage about an exceptional lady physician is being preserved for future generations. This turned out to be a most interesting and educational project.

"Heritage is something that is transmitted by or acquired from a predecessor—a legacy. Kentucky medicine has been richly endowed with physicians who left a most worthwhile legacy."

Just who is Dr Louise? Many of you will remember from the "Mediscope" that Dr Louise Gilman Hutchins, a pediatrician, was a pioneer in family planning for women of Eastern Kentucky. She was born in Changsha, China, where her parents were missionaries, and served her medical internship caring for refugee children on the Chinese mainland during the war years of 1936-39. She arrived in Berea, Kentucky in 1939 with her husband Francis Hutchins who had been named President of Berea College. Even with her experience in China, she was appalled at the stories she heard and the situations she saw when she arrived in Kentucky. In 1939, it was very common for a woman in Eastern Kentucky to mark her 30th birthday by giving birth to her 10th child. In many cases, the children numbered 12 or more. Not only were these mountain women unable to care for their children, they were literally dying from having too many babies too quickly. Dr Louise was a firm believer in what was at the time a highly controversial concept—family planning. As a colleague put it, Dr Hutchins began "bootlegging" family planning to Eastern Kentucky. The family planning pioneer traveled thousands of miles, seeing thousands of patients and training nurses to dispense information and materials. For her work, Dr Hutchins received many honors. Among them, the Lane Bryant Award for Distinguished Volunteer Service; The Margaret Sanger Award from the Planned Parenthood Federation of America; The Kentucky Public Health Association's Helen B. Fraser Award for outstanding service on behalf of mothers and children. She was named a Kentucky Woman of the Year in 1991.

Dr Louise passed away in September 1996. Now is the time to acquire information about her while so many people who knew her are still available for personal interviews. It is most appropriate to preserve the history of this physician's unusual contributions to improve the quality of life for those people she so aptly served. It was my personal privilege to have known Dr Louise for 30 years.

This video is being presented to the KMA Library in hopes it will help preserve just one more small piece of medical heritage in Kentucky. Heritage is something that is transmitted by or acquired from a predecessor—a legacy. Kentucky medicine has been richly endowed with physicians who left a most worthwhile legacy. History is one's tale or story of past events. In the future, perhaps we can work together to preserve more history of these worthwhile and significant contributions.

May you and your family have a wonderful Holiday Season and create memories that will be cherished for many years to come.

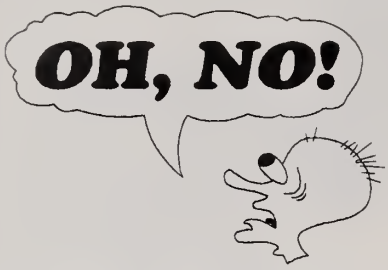
Jan Crase
KMAA President

Note: The video was exhibited at the Southern Medical Association Annual Meeting in New Orleans in November, 1998.

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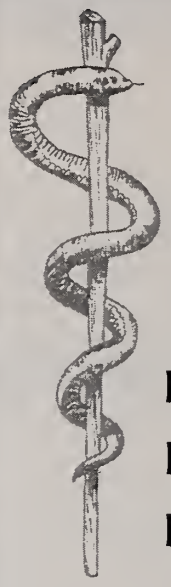
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148th KMA Annual Meeting

Top left, Donald R. Stephens, MD, Cynthiana, took the President's Inaugural Oath, administered by Board Chair J. Gregory Cooper, MD, also of Cynthiana. Top right, President-Elect Harry W. Carloss, MD, Paducah, addressed the House following his election. Bottom, the outgoing President and First Lady, Ken and Rhoda Peters, welcomed the newly inaugurated President and First Lady, Don and Sonia Stephens.













Top, President Stephens was joined by his immediate officers, l to r, Vice President Dr Don Neel, Secretary-Treasurer Dr Bill VonderHaar, and President-Elect Dr Harry Carloss. Right, the President delivered his Inaugural Address. Center left, AMA President Nancy Dickey, MD, was honored as a Kentucky Colonel. She was most grateful, acknowledging that this distinction was "almost as good as being an Aggie." Dr Ken Peters made the presentation. Right, newly installed President Stephens presented the Past President's plaque to Dr Ken Peters. Bottom, President-Elect Dr Harry Carloss turned to acknowledge the congratulations of his colleagues as he was escorted to the podium by two KMA Past Presidents, Dr Bob Goodin, left, and Dr Wally Montgomery.







Top, Dr Stephens and his wife Sonia were delighted that all five of their children shared in this very special day. Pictured left to right are daughter Jane, daughter-in-law Laura, son Doug, the Stephens, son Dennis, daughter Susan and her husband Michael Grieff. The Stephens' eldest son Don Jr, an attorney, was present for the inauguration ceremony, but a business commitment required that he leave prior to the photo session. Center, Awards Chair Dr Richard Hench of Lexington presented the Lay Person Award to Henry C. Wagner of Louisville. Bottom, the Educational Achievement Award went to Gordon L. Hyde, MD, of Lexington. President Ken Peters was pleased to make the presentation.

Inauguration

Donald R. Stephens, MD, a Cynthiana family physician, was inaugurated 1998-99 President of KMA at the 148th Annual Meeting held in Louisville, September 21-24. A 1960 graduate of the University of Louisville School of Medicine, Dr Stephens served 23 years as 9th District KMA Delegate, several years as an Alternate Trustee, three terms as Trustee, and two terms as Board Chair prior to his election as Vice President for 1995-96. He subsequently was named President-Elect. He is a member of the PLI, Public Education, Scientific Program, and Legislative Quick Action Committees.

Dr Stephens is a diplomate of the American Board of Family Practice, a charter fellow of the American Academy of Family Physicians, and a member of numerous professional associations.

Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1998-99 Association year on September 24, 1998. Acting Chair William P. VonderHaar, MD, introduced the newly



elected members of the Board and the new officers. Harry W. Carloss, MD, Paducah, has been named President-Elect, and Donald R. Neel, MD, Owensboro, was elected Vice President. Following his election, Dr Neel vacated his position as 2nd District Trustee. Alternate Trustee David A. Watkins, MD, Henderson, assumed the 2nd District Trustee position. Newly elected Trustees were Uday V. Dave, MD, Madisonville, 3rd District, and Baretta R. Casey, MD, Pikeville, 14th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1998-99 KMA year. J. Gregory Cooper, MD, Cynthiana, was reelected Chair, Board of Trustees, and Meredith J. Evans, MD, Middlesboro, was elected Vice Chair of the Board. Kenneth R. Hauswald, MD, Ashland, and Thomas E. Bunnell, MD, Crestview Hills, were named as Trustees-at-large.

The next meeting of the Board was scheduled for November 18-19, 1998.

Five physicians were elected by the House of Delegates to serve on the 1999 Nominating Committee. Members elected were:

Barbara A. Phillips, MD, Lexington, Chair
David E. Bybee, MD, Louisville
Linda Mumford, MD, Owensboro
J. Roger Potter, MD, Ashland
Scott A. Watkins, MD, Henderson

President's Luncheon

The President's Luncheon guests honored outgoing President C. Kenneth Peters, MD, and witnessed the installation of Donald R. Stephens, MD, as the 148th President of KMA.

Dr Stephens' Inaugural Address focused on patient protection and the problems brought on by managed care and its failure to address the systemic problems that existed before managed care came on the scene, and that still remain. Notable comments included:

"James Baldwin wrote. 'the price one pays for pursuing any profession, or calling, is an intimate knowledge of its ugly side.' Physicians, nurses and other medical professions empathize with Baldwin's truths. Medical professionals recognize 'in a heart beat' the ugly side of health care in today's HMOs and managed care system. From the get go, physicians warned that HMOs were ignoring traditional market



Top, DSA honoree Bob M. DeWeese, MD, was joined by his family for this very happy occasion. Pictured, l to r, son John, Dr DeWeese, wife Angie, daughter Amy, and sons Craig and Steve. Above, Secretary-Treasurer William P. VonderHaar, MD, addressed the House of Delegates.







Top, Alliance Immediate Past President Aroona Dave presented an AMA Foundation check to University of Kentucky College of Medicine Dean Emery Wilson, MD. Center, Laura Schweitzer, PhD, Associate Dean of Faculty Affairs and Student Affairs, accepted the check for the University of Louisville. Alliance President-Elect Carolyn Daley joined Mrs Dave in presenting the checks. Bottom, James P. Farrell, MD, Crestview Hills, commented on a resolution before the House.

forces that drive health care costs, and that the same fate that befell traditional health insurers would visit HMOs. But nobody cared, so long as the losers were physicians, hospitals, and nurses . . . .The abuses of managed care lead us to an even more sobering concern. There is a growing inevitability that we are on the brink of a single source payment plan. That may be the only option remaining for health care providers and their patients to compensate for an impersonal and unbridled HMO and an intransigent Congress."

Dr Stephens' address is printed in its entirety in the October 1998 *Journal.*

DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1998 recipient of the Association's most prestigious honor, the Distinguished Service Award, was bestowed upon Bob M. DeWeese, MD, a retired Louisville surgeon currently serving as a Kentucky State Representative. He was honored at the President's Luncheon not only for his contributions to the profession but also to his community.

In presenting the award to Dr DeWeese, Awards Chair Richard F. Hench, MD, of Lexington included these comments:

"Every year we receive many deserving nominations and 1998 was no exception. However, one candidate stood out this year—a gentleman whose persistence and efforts affected every single individual in this room. The 1998 honoree is a native of Ballard County and received his undergraduate degree from the University of Kentucky. He graduated from the University of Louisville School of Medicine and completed his internship and residency at University of Louisville Hospitals. Our award recipient practiced general surgery in Louisville for over 30 years. He is a fellow of the American College of Surgeons, and member of numerous surgical and medical societies and associations.

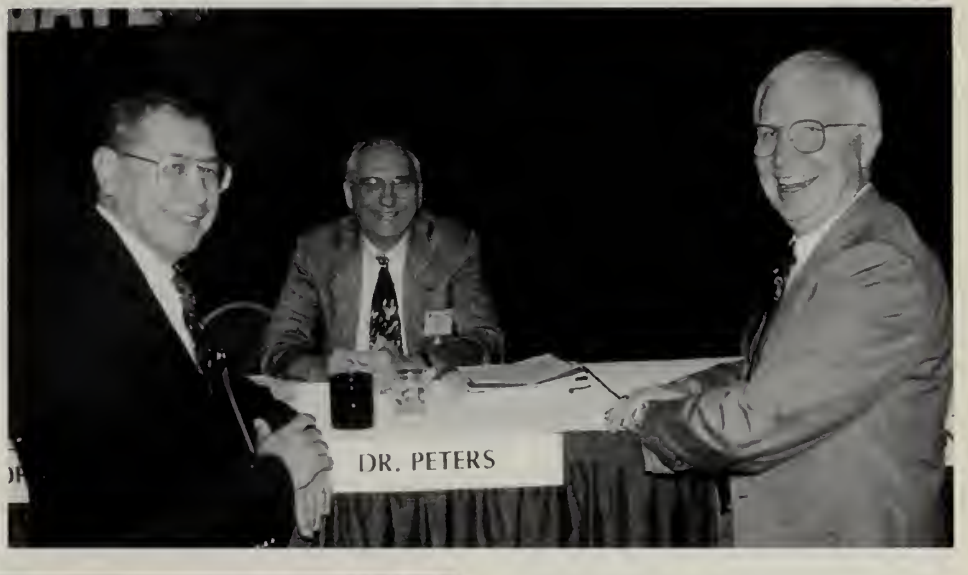
The 1998 award recipient has been extremely active in his profession and has served as a leader in practically

every medical organization in which he has been involved. He has served as President of several Louisville hospital medical staffs, and is a past president of the Jefferson County Medical Society. After many years of service to his local medical community, our honoree transferred his talents to his state medical association. He was elected Trustee from Jefferson County and served two full terms. In September 1988 he was installed as President of the Kentucky Medical Association. Today's honoree remains active in medical and professional affairs by serving on the KMA Board of Trustees as Alternate Delegate to the American Medical Association.

Wherever this gentleman has served, he has become widely known for his patient advocacy. His public battles with for profit hospitals, government, and insurance companies, is legend. Due to medical problems; our recipient retired from active medical practice. Unlike many who "truly retire," the 1998 recipient of the Distinguished Service Award searched for new avenues to utilize his talents. He, along with his family and strong support from his friends and colleagues, decided to seek public office. In his first effort, a huge majority of Jefferson County voters in House









Clockwise from top left, Jefferson County President Barton H. Reutlinger, MD, a Louisville orthopedic surgeon, addressed an issue under consideration in a Reference Committee. Daniel W. Varga, MD, a Louisville internist, remarked on a resolution before the House. KMA Past Presidents, Drs Bill Mitchell and Ken Peters, relaxed with President Stephens during a break in House action. Rural Caucus members studying the agenda were, l to r, Drs William Mitchell, Richmond; James Shockey, Pikeville; Mary Jo Ratliff, Pikeville; Nicholas Jurich, Prestonsburg; and Gregory Hazelett, Pikeville.





KMA Board Chair Greg Cooper and his wife, Debbie, congratulated President Stephens and his wife, Sonia. Right, House Speaker, John McClellan, MD, directed the House of Delegates meetings from the podium. Vice Speaker Thomas Slabaugh, MD, assisted in conducting the meetings.

District 48 elected him to the Kentucky General Assembly as State Representative. In 1994, he was at the forefront in medicine's unsuccessful fight against the provider tax and the disastrous HB 250, the so-called "health reform bill." On numerous occasions, our honoree warned fellow lawmakers not to enact HB 250 and cited specific concerns with patient care, access, and cost. The rest is history. HB 250 was a disaster. In 1996, he helped write legislation repealing the provider tax and onerous portions of HB 250, developed proposals to restore credibility to Medicaid, and sponsored numerous patient oriented bills.

However, it was the 1998 Session that brought this gentleman statewide recognition. He is now widely recognized as one of Kentucky General Assembly's most effective members. He, along with his good friend Bob Damron, State Representative from Jessamine County, worked during the interim legislative period drafting legislation to address the health insurance crisis. Although they failed to prevail in the 1997 Special Session, they re-introduced the bill in 1998. Through their persistence, the General Assembly enacted House Bill 315. House Bill 315 dramatically altered the climate of health insurance in this state, and also contained KMA's Patient Protection/Provider Fairness provisions. House Bill 315 provides Kentuckians some of the most far-reaching patient rights in the US.

At the close of each Session, members of the General Assembly, lobbyists, and the media are asked to rate members of the General Assembly. In 1998 our nominee was ranked as one of the ten most effective legislators in the Commonwealth. In areas of integrity, character, and leadership he ranked at or near the top in all categories. We are pleased to say that in our ratings, he finished number one."

Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, was presented to Henry C. Wagner of Louisville. Mr Wagner has been a member of the Jewish Hospital staff since 1973 and has served as President and CEO of Jewish Hospital or Jewish Hospital HealthCare Services since 1980.

Awards Chair Hench noted the following in his presentation of the award to Mr Wagner:

"Active in civic and community affairs, Mr Wagner has served in numerous capacities for the Louisville Chamber of Commerce, Louisville Downtown Development Corporation, Economic Development Strategic Committee for Greater Louisville Region, and the Kentucky Chamber of Commerce.

A major player in the development of arts and music in Kentucky, Henry Wagner has served as Chairman of the Board of Directors Funds for the Arts, J.B. Speed Art Museum, Kentucky Center for Performing Arts, and the Louisville Orchestra.

Mr Wagner has also been extremely active in the education arena having served on the Board of Trustees of the University of Louisville, St. Francis School, and Spalding College.

Our 1998 honoree has a remarkable record in improving relationships and communications between races and religions. Mr Wagner has served as Chair of the Black Achievers Annual Dinner, National Conference of Christians and

Jews, and Chair of the Louisville Chamber of Commerce Community Affairs African-American Committee. He has received numerous awards for his religious and interracial activities including the National Conference of Christians and Jews Annual Award, the YWCA Black Achievers Annual Award, Jewish Family and Vocational Service Award, and the Louisville Urban League Equality Award.

Mr Wagner spends considerable time working in various fundraisers, especially those related to health and medical care. He has served in various capacities in the Arthritis Foundation, Multiple Sclerosis Society, Task Force on AIDS, AIDS fundraisers, and the Society to Prevent Blindness.

The recipient of the 1998 KMA Outstanding Layperson Award has devoted most of his adult life to improving quality and access to health and medical care for all citizens. He has been a major player in preparing and implementing strategic regional plans, which has seen the development of one of America's finest health systems right here in downtown Louisville. While he has been a leader in positioning Jewish Hospitals at the forefront of medical technology and innovation, he has not ignored the necessity of championing the community's entire medical delivery system. He has worked tirelessly with physicians, the medical school, hospitals, and the civic community to expand opportunities for citizens, employees, the state and the local community."





Above, AMA President Nancy W. Dickey, MD, was seated with, l to r, Bruce A. Scott, MD, a Louisville otolaryngologist recently elected to a Young Physician position on the AMA Board of Trustees, and AMA Delegate Wally O. Montgomery, MD, of Paducah. Left, a fellow 1960 U of L Medical School graduate and KMA Past President, Donald C. Barton, MD, Corbin, congratulated his friend and former classmate. Immediate Past President Ken Peters was also a graduate of that 1960 class.

Educational Achievement Award

The recipient of the 1998 KMA Educational Achievement Award was Gordon L. Hyde, MD, of Lexington. President Ken Peters was pleased to present the award to Dr Hyde and included the following comments in his presentation:

"Our honoree is Professor Emeritus of Surgery at the University of Kentucky College of Medicine, having served on the faculty there since 1963. During his time with the Department, he served as Chief of the Section of Vascular Surgery and had a major influence on residents and medical students through his efforts in the areas of substance abuse, quality of patient care, medical education, as well as classroom and bedside teaching. More recently, he has been investigating the field of minimally invasive vascular surgery and continues to publish actively.

A major interest has been in the field of medical addiction and rehabilitation of impaired physicians. He initiated and organized the Annual Medical Student Day on Alcoholism and Drug Abuse at UK and served on the Governor's Task Force on Drug and Alcohol Abuse under four Governors from 1978 to 1988.

He has been a member of KMA's impaired Physicians Committee since 1982 and now serves on the Kentucky Physicians Health Foundation Committee. He wrote and cast the video "Out of Control," produced by the American College of Surgeons. This video is shown worldwide and addresses the issue of substance abuse among physicians and residents.

Our honoree was twice recipient of the "Master Teacher Award" by the University of Kentucky, in 1994 and 1995. In addition, the residents established an award in his name in 1981 for a faculty member contributing the most to the University of Kentucky Residency Program and honored him as the first recipient.

He is Board Certified in General Surgery, as well as Vascular Surgery and Addiction Medicine. He is also

a Fellow of the American College of Surgeons and American Society of Addiction Medicine; a founding member of the Kentucky Vascular Surgery Society and Southern Association for Vascular Surgery; a member of the American Medical Association, Kentucky Medical Association; and the Fayette County Medical Society, to name a few.

In community service, he is currently involved in fundraising activities and trying to promote alcohol treatment programs at the men's and women's halfway in Lexington."

Alliance AMA-ERF

During the first meeting of the House of Delegates, Aroona Dave, KMAA Past President, presented AMA-ERF (recently renamed AMA Foundation) checks to the two medical schools on behalf of the Alliance. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding $2 million annually. The extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Laura Schweitzer, PhD, Associate Dean of Faculty Affairs and Student Affairs, at the University of Louisville School of Medicine, accepted a check from Mrs Dave for $21,637.40, and Emory A. Wilson, MD, Dean of the University of Kentucky College of Medicine, accepted a check for $16,828.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50 years or more were recognized during the President's Luncheon, Achieving that status this year are: Drs Harold W. Baker, Charles G. Campbell, Samuel H. Cheng, John E. Cotthoff, Kenneth M. Eblen, Lawrence P. Emberton, C. Wayne Franz, Oskar P. Friedlieb, James W. Harkess, J. Kenneth Harris, Thomas J. Huth, Graydon A. Long, Robert W. Morrissey, Theodore T. Myre, Bogdan Nedelkoff, Louis J. Nutini, Paul J. Parks, Francis J. Peisel, R. J. Phillips, Jr, Irene E. Roeckel, Frank A. Shemwell, Ben C. Stigall, Edward Warrick, Jr, and Harold F. West.



Carolyn S. Watson, MD, Paducah, enjoyed a light moment during House action.

In Memoriam

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 485 of this *Journal*.

KEMPAC

The 36th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 21, at the Hyatt Regency Hotel, Louisville. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard opening remarks by KMA President C. Kenneth Peters, MD. The featured speaker was Ernie Fletcher, MD, a candidate for US Congress. KEMPAC Chair, William B. Monnig, MD, Edgewood, presided at the meeting.

House Action Summary

The Association's policymaking body, the House of Delegates, met on September 21 and again on September 23 and considered more than 40 reports, 30 Resolutions, and several organizational and special reports. The House unanimously adopted a strategic plan entitled "KMA Future Search." This plan emerged from a two-day retreat held in May 1998 and attended by a cross section of KMA members. The plan also incorporated results from a member survey and interviews from non-physician decision makers to determine their views of the Association and its image and activities.

Major themes and priorities adopted from the strategic plan include:

- Maximize physician participation in organized medicine by enhancing services and facilitating better communications to members and targeting non-members for outreach. Work toward a 90% participation rate within five years.
- Ensure an effective, year-round government program and seek a balanced partnership with government. Continue efforts to achieve tort reform and serve as a resource for medico-legal issues.
- Preserve the doctor/patient relationship and emphasize the goal of "putting the patient first" as central to the integrity of medicine.
- Position KMA to be a more active leader and advocate in influencing the managed care environment and to serve as a clearinghouse (referral source) of information for practicing physicians. Foster outcomes-driven quality of care across the state in the next five years.
- Take a proactive role in defining and responding to the educational and ethical challenges arising from the





Susan E. Spires, MD, Lexington, above, pondered the House of Delegates agenda with her Fayette County colleagues. William B. Monnig, MD, KEMPAC Chair, presented his annual report to the House.

new frontiers of medical knowledge.
- Establish new connections and strengthen existing physician ties with the broader health care community and the public at large.
- Achieve universal access to health care for Kentuckians within five years.

The Delegates adopted several Resolutions including:
- Physician Education on End-of-Life Care—urged Kentucky physicians to be aware of the AMA Education for Physicians on End-of-Life Care ("EPEC") program and make themselves available for the educational programs offered by EPEC.
- Vaccine for Children—urged Congress to amend federal law to make children covered by State Children Health insurance programs eligible for Vaccine for Children.
- Universal Vaccine—directed KMA to explore the feasibility of pursuing implementation of the Universal Vaccine Program in Kentucky.
- Women in Medicine—recognized September as "Women in Medicine" month, and urged women to be more involved in the leadership of medicine; urged KMA to continue appointing women to crucial leadership and policy making positions, and recommended that women participate in the Women Physicians Congress.
- Membership Recruitment—endorsed a member-get-a-member campaign.
- Managed Care—encouraged physicians to become more involved in the design, implementation, and operation of managed care systems and work to modify fault.
- Insurance Department Enforcement of Late Payment Statutes—directed that KMA introduce legislation to require third-party payers to pay electronically submitted claims within 15 days; notify physicians within 30 days if a claim is inadequately prepared; ask Department of Insurance to track complaints on third-party payers and make information available to physicians; use all legislative and legal means to ensure that the law applies to all third-party payers including those covered under ERISA law.

Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

Attendance

This year's KMA meeting attracted a crowd of 2,042. Physicians numbered 1,105 and medical students 121, resulting in a very successful 148th KMA Annual Meeting at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. The 1999 Annual Meeting will be held in Lexington. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Lexington Center to house the meeting. Over 22 specialty groups and an estimated 2200 registrants are expected to attend.

Please mark your calendars to attend the 1999 KMA Annual Meeting to be held September 26-29.

KEMPAC



Newly elected KEMPAC Board Chair Robert D. Woods, MD; Representative Robert R. Damron.



Angie DeWeese, wife of Representative Bob M. DeWeese, MD; KMA Alliance President Jan Crase; KMA Board Chair Greg Cooper, MD.



KEMPAC Treasurer Michael W. Dee, MD; Representative Ron E. Crimm, Louisville.



Outgoing KEMPAC Chair William B. Monnig, MD.



The evening's featured speaker, Congressional Candidate Ernie Fletcher, MD.



Representative Charlie Walton; Dr Michael R. Kirkwood; KEMPAC Board Member Carol Kirkwood.

A distinguished group of state leaders, KMA members, and their spouses attended the KEMPAC Seminar Banquet held during the Annual Meeting. KEMPAC Chair William B. Monnig, MD, presided at the meeting. Several in attendance are pictured in this two-page feature.

PAC



Representatives Bob Damron and Dr Bob DeWeese, and KEMPAC Chair Bill Monnig, MD.



Senator John D. "Jack" Westwood.



State Representative Jesse Crenshaw.



Representatives Mary Lou Marzian and James P. Callahan.



Lieutenant Governor Steven Henry, MD; KEMPAC Administrative Assistant Jeanette Thompson.



Representative Damron with Dr and Mrs (Glenna) Ernie Fletcher.



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The most effective way to recruit new members is through a personal conversation or note conveying your own thoughts about why you are a member. You will receive a Recruitment Kit containing support materials when you sign up.

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4-6 new active members	35mm Camera
7-9 new active members	Digital Camera
10+ new active members	Laptop Computer

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ROLL CALL
1998 House of Delegates
1st Meeting September 21, 1998
2nd Meeting September 23, 1998

OFFICERS

		First Meeting	Second Meeting
Speaker	Jahn W. McClellan, Jr, MD	Present	Present
Vice-Speaker	Thomos K. Slabough, MD	Present	Present
President	C. Kenneth Peters, MD	Present	Present
President-Elect	Danald R. Stephens, MD	Present	Present
Vice-President	Harry W. Carlass, MD	Present	Present
Secretary-Treasurer	William P. VonderHaar, MD	Present	Present
AMA Delegate	Donald C. Bartan, MD	Present	Present
AMA Delegate	Wally O. Mantgamery, MD	Present	Present
AMA Delegate	Rabert R. Goadin, MD	.....	Present
AMA Delegate	Ardis D. Haven, MD	.....	.....
AMA Delegate	Danald J. Swikert, MD	Present	Present
AMA Alternate Delegate	Bob M. DeWeese, MD	Present	Present
AMA Alternate Delegate	J. Gregory Caaper, MD	Present	Present
AMA Alternate Delegote	Prestan P. Nunnelley, MD	Present	Present
AMA Alternate Delegate	William B. Mannig, MD	Present	Present
AMA Alternate Delegote	Baretta R. Casey, MD	Present	Present

TRUSTEES

District			
First District	Rabert C. Hughes, MD	Present	.....
Secand District	Donald R. Neel, MD	Present	Present
Third District	C. R. Dodds, MD	Present	.....
Faurth District	Eugene H. Shively,MD	Present	Present
Fifth District	Doniel W. Varga, MD	Present	Present
Sixth District	Jahn T. Burch, II, MD	Present	Present
Seventh District	John M. Pattersan, MD	Present	Present
Eighth District	Thomos E. Bunnell, MD	Present	Present
Ninth District	J. Gregory Cooper, MD	Present	Present
Tenth District	Andrew R. Pulita, MD	Present	Present
Eleventh District	Richard A. Stane, MD	Present	Present
Twelfth District	Donold E. Brawn, MD	Present	Present
Thirteenth District	Kenneth R. Houswold, MD	Present	Present
Faurteenth District	E. D. Raberts, MD	Present	Present
Fifteenth District	Meredith J. Evons, MD	Present	.....

ALTERNATE TRUSTEES

District			
First District			
Secand District	Dovid A. Watkins, MD	.....	Present
Third District	Uday V. Dave, MD	Present	Present
Faurth District	Brian F. Wells, MD	Present	.....
Fifth District	Suson M. Berberich, MD	.....	Present
Sixth District	J. Michael Pulliam, MD	Present	Present
Seventh District	Kenneth L. Oder, MD	.....	Present
Eighth District	Jomes P. Forrell, MD	Present	Present
Ninth District	Judy M. Linger, MD	Present	Present
Tenth District	Jahn R. White, MD	Present	Present
Eleventh District	Suvos G. Desoi, MD	.....	.....
Twelfth District	David C. Liebschutz, MD	Present	Present
Thirteenth District	Maurice J. Ookley, MD	Present	.....
Faurteenth District	Boretto R. Casey, MD	Present	Present
Fifteenth District	David W. Dauglas, MD	.....	Present

PAST PRESIDENTS

Past President	William H. Mitchell, MD	Present	Present
Past President	Danny M. Clark, MD	Present	Present
Past President	Rabert R. Goadin, MD	.....	Present
Past President	Ardis D. Haven, MD	.....	.....
Past President	William B. Mannig, MD	Present	Present

DELEGATES
FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD	Martha C. Robinsan, MD, Barlaw	.....	.....
CALLOWAY	Rabert Williams, MD, Murroy	Present	.....
CARLISLE			
FULTON			
GRAVES	Charles E. Bea, MD, Mayfield	.....	.....
	Gerald Russell, MD, Mayfield	.....	.....
HICKMAN			
LIVINGSTON	Stephen Burkhort, MD, Salem	.....	.....
MARSHALL			
MCCRACKEN	Caralyn Watson, MD, Paducah	Present	Present

SECOND DISTRICT

DAVIESS	William Harrisan, MD, Owensboro	.....	Present
	David Janes, MD, Owensboro	Present	Present
	Wathen Medley, MD, Owensbora	Present	Present
	William Milnar, MD, Owensboro	Present	Present
	M. Anworul Quoder, MD, Owensbaro	.....	Present
	Terry Tyler, MD, Owensboro	Present	Present
	William Tyler, MD, Owensbaro	Present	Present
HANCOCK			
HENDERSON	Jahn S. Cave, MD, Henderson	Present	.....
	Morshall G. Howell, III, MD, Henderson	.....	.....
	David Watkins, MD, Hendersan	Present	Present
MCLEAN			
OHIO			
UNION			
WEBSTER			

THIRD DISTRICT

CALDWELL			
CHRISTIAN	Robert B. Bressler, MD, Hopkinsville	.....	.....
	Ratilal Gajera, MD, Hopkinsville	.....	.....
	Jomes C. King, Jr, MD, Hopkinsville	.....	.....
	Michael Murroy, MD, Hopkinsville	.....	.....
	J. Nicholos Terhune, MD, Hopkinsville	.....	.....
CRITTENDEN			
HOPKINS	Wolloce R. Alexander, MD, Madisanville	Present	Present
	James Bowles, MD, Modisonville	Present	Present
	Uday V. Dave, MD, Modisonville	Present	Present
	Allen Elliott, MD, Modisanville	Present	Present
LYON	Steve Hilond, MD, Eddyville	.....	.....
MUHLENBERG			
TODD	Henry R. Bell, MD, Elkton	.....	.....
TRIGG			

FOURTH DISTRICT

BRECKINRIDGE	Jomes G. Sills, MD, Hordinsburg	.....	.....
BULLITT			
GRAYSON	Gay Fulkersan, MD, Leitchfield	.....	Present
GREEN	William Shuffet, MD, Greensburg	.....	Present
HARDIN	Lucion Maremon, MD, Elizabethtawn	.....	.....
	Jeffrey Richardsan, MD, Elizobethtawn	Present	Present
	David Zaeller, MD, Elizabethtawn	Present	Present
HART			
LARUE			
MEADE	Raymand L. Mathis, DO, Brandenburg	.....	.....
MARION	Richard V. Steeves, MD, Lebanan	.....	.....
NELSON			
TAYLOR	David Mantgamery, MD, Campbellsville	.....	.....
WASHINGTON	Brian Wells, MD, Springfield	Present	.....

FIFTH DISTRICT

JEFFERSON	Jannice O. Aoron, MD, Louisville	.....	Present
	Dovid T. Allen, MD, Louisville	Present	Present
	Kenneth C. Anderson, MD, Louisville	.....	Present
	Joe F. Arterberry, MD, Louisville	Present	.....
	Chorles Bisig, Jr, MD, Louisville	.....	Present
	Dovid H. Bizot, MD, Louisville	.....	Present
	Suson G. Bornstein, MD, Louisville	.....	Present
	Dovid E. Bybee, MD, Louisville	Present	Present
	Peter C. Compbell, MD, Louisville	.....	Present
	Worren M. Cox, MD, Louisville	.....	Present
	J. H. Doyle, MD, Louisville	Present	Present
	Elmer E. Dunbor, MD, Louisville	Present	.....
	R. John Ellis, MD, Louisville	.....	Present
	J. T. Govin, Jr, MD, Louisville	.....	Present
	Lindo H. Gleis, MD, Louisville	.....	Present
	Leonord A. Goddy, MD, Louisville	.....	.....
	Monuel Grimoldi, MD, Louisville	.....	Present
	Jomes Hoile, MD, Louisville	Present	.....
	Horold D. Holler, Sr, MD, Louisville	.....	Present
	Wolter I. Hume, MD, Louisville	Present	Present
	Borboro S. Isoocs, MD, Louisville	.....	Present
	Sheri A. Kolbfleisch, MD, Louisville	.....	Present
	Virginio T. Keeney, MD, Louisville	Present	Present
	Stephen Kirzinger, MD, Louisville	.....	Present
	Donold R. Kmetz, MD, Louisville	.....	.....
	Glenn E. Lombert Jr, MD, Louisville	.....	.....
	Renoto LoRocco, MD, Goshen	.....	Present
	Rudolph F. Licondro, MD, Louisville	.....	.....
	Gerlindo L. Lowrey, MD, Louisville	.....	.....
	Michoel T. Mocforlone, MD, Louisville	.....	.....
	W. Poul McKinney, MD, Louisville	.....	.....
	Chorles F. Mohl, MD, Louisville	.....	.....
	Fronk B. Miller, MD, Louisville	.....	.....
	Alice E. Minter-Souer, MD, Louisville	.....	.....
	Seon Murphy, MD, Louisville	.....	Present
	Dovid Neustodt, MD, Louisville	.....	Present
	Hobert Pence, MD, Louisville	.....	Present
	Hugh Peterson, MD, Louisville	.....	Present
	Mork E. Petrik, MD, Louisville	.....	.....
	Mork P. Pfeifer, MD, Louisville	.....	.....
	Potricio M. Purcell, MD, Louisville	.....	.....
	Steven J. Roible, MD, Louisville	.....	.....
	Julio A. Romirez, MD, Louisville	.....	.....
	Bernord O. Rond, MD, Louisville	.....	Present
	Jomes E. Redmon, Jr, MD, Louisville	Present	Present
	K. Thomos Reichord, MD, Louisville	.....	.....
	Steven Reiss, MD, Louisville	.....	Present
	Borton Reutlinger, MD, Louisville	Present	Present
	Peter W. Ross, MD, Louisville	.....	.....
	Somuel R. Scheen,III, MD, Louisville	.....	Present
	G. Rondolph Schrodt Sr, MD, Louisville	.....	Present
	G. Rondolph Schrodt Jr, MD, Louisville	.....	Present
	Edword L. Scofield, MD, Louisville	Present	Present
	Jerry W. Seligmon, MD, Louisville	.....	Present
	Monico A. Shaw, MD, Louisville	.....	Present
	Rojesh Sheth, MD, Louisville	.....	Present
	Victor Shpilberg, MD, Louisville	.....	Present
	Judoh L. Skolnick, MD, Louisville	.....	.....
	Bernord L. Speevock, MD, Louisville	.....	Present
	Suson Spires, MD, Louisville	.....	Present
	Eloine Stouble, MD, Louisville	.....	Present
	Gerold D. Temes, MD, Louisville	.....	.....
	Rebecco A. Terry, MD, Louisville	.....	.....
	Robert S. Tillett, Jr, MD, Louisville	.....	Present
	Regulo J. Tobios, MD, Louisville	.....	Present
	Stuort Urboch, MD, Louisville	.....	.....
	Doniel W. Vargo, MD, Louisville	Present	Present
	Molloy G. Veol, MD, Louisville	Present	Present
	Henry J. Wolter, MD, Louisville	.....	.....
	Nortan G. Wotermon, MD, Lauisville	.....	.....
	Dovid Wotkins, MD, Lauisville	.....	Present
	Somuel D. Weokley, MD, Lauisville	Present	Present
	G. Derek Weiss, MD, Louisville	.....	.....
	Fred A. Willioms, MD, Louisville	.....	.....
	Russell A. Willioms, MD, Lauisville	.....	.....
	C. Milton Young, MD, Louisville	Present	Present
	Jonice W. Yusk, MD, Louisville	.....	.....
	George Zenger, MD, Louisville	.....	Present

SIXTH DISTRICT

ADAIR			
ALLEN			
BARREN	Worren J. Eisenstein, MD, Glosgow	.....	.....
	Mike Smith, MD, Glosgow	.....	.....
BUTLER			
CUMBERLAND			
	Joseph D. Skipworth, MD, Burkesville	.....	.....
EDMONSON	Omkor N. Bhott, MD, Brownsville	.....	.....
LOGAN			
METCALF			
MONROE			
SIMPSON			
WARREN	Jomes Beottie, MD, Bowling Green	Present	Present
	Mork E. Bigler, MD, Bowling Green	Present	Present
	Robert Emslie, MD, Bowling Green	Present	Present
	Jone Bromhom, MD, Bowling Green	Present	Present

SEVENTH DISTRICT

ANDERSON			
CARROLL	Somer Hussein, MD, Corrollton	.....	.....
FRANKLIN	Joseph J. Dobner, MD, Fronkfort	.....	.....
	Arbo L. Kenner, MD, Fronkfort	Present	Present
	John M. Potterson, MD, Frankfort	.....	.....
GALLATIN	Benjomin Kutnicki, MD, Worsow	.....	Present
GRANT			
HENRY	Dovid Jones, MD, Eminence	.....	.....
OLDHAM	Brooks Jockson, MD, Shelbyville	.....	.....
OWEN			
SHELBY	Ron Woldridge, MD, Shelbyville	Present	Present
SPENCER	Kenneth Oder, MD, Toylorsville	.....	Present
TRIMBLE	Fronk Polmer, MD, Bedford	.....	.....

EIGHTH DISTRICT

BOONE	Allon Hollquist, MD, Edgewood	Present	Present
	Neol Moser, MD, Crestview Hills	.....	.....
	Michoel Robinson, MD, Edgewood	.....	.....
CAMPBELL	Steve Steinkomp, MD, Edgewood	.....	.....
KENTON	Gordin Air, MD, Crestview Hills	Present	Present
	Stephen Bernordon, MD, Edgewood	Present	Present
	Chris Bolling, MD, Crestview Hills	Present	.....
	Thomos Bunnell, MD, Crestview	Present	Present
	Michael Dovenport, MD, Toylor Mill	.....	Present
	Jim Forrell, MD, Crestview Hills	Present	Present
	Michoel Kirkwood, MD, Edgewood	Present	Present
	Joe Martin, MD, Cold Spring	.....	Present
	Ross McHenry, MD, Edgewood	.....	Present
	Ted Miller, MD, Edgewood	Present	Present
	Richord Pork, MD, Edgewood	.....	Present
	Bob Schwortz, MD, Edgewood	.....	.....

NINTH DISTRICT

BATH			
BOURBON	Victar Lowson, MD, Poris	Present	Present

BRACKEN			
FLEMING	Glenn R. Womock, MD, Flemingsburg	.....	.....
HARRISON	Todd Ussery, MD, Cynthiono	.....	.....
MASON	Dovid Doty, MD, Moysville	.....	.....
NICHOLAS	Wendell R. Kingsolver, MD, Corlisle	.....	.....
PENDLETON			
ROBERTSON			
SCOTT			

TENTH DISTRICT

FAYETTE	James W. Boker, MD, Lexington	.....	.....
	Jomes R. Beon, MD, Lexington	Present	Present
	Fronk A. Burke, MD, Lexington	.....	Present
	Terry Clark, MD, Lexington	.....	Present
	John W. Collins, MD, Lexington	Present	Present
	Max Crocker, MD, Lexington	.....	Present
	W. Lisle Dolton, MD, Lexington	Present	Present
	Jomes E. Dunnington, MD, Lexingtan	Present	Present
	John M. Fox, MD, Lexington	Present	Present
	Terrence R. Grimm, MD, Lexingtan	.....	.....
	Terence L. Gutgsell, MD, Lexington	.....	Present
	Michoel D. Hogen, MD, Lexington	Present	Present
	Bill H. Horris, MD, Lexington	Present	.....
	John M. Horris, MD, Lexington	.....	.....
	Richord Hench, MD, Lexington	Present	Present
	Tomoro Jomes, MD, Lexington	.....	.....
	Mogdolene B. Koron, MD, Lexington	Present	Present
	Dennis B. Kelly, MD, Lexington	Present	Present
	Doniel E. Kenody, Sr, MD, Lexington	Present	Present
	Gerold V. Klim, DO, Lexington	.....	Present
	Arthur Lieber, MD, Lexington	.....	Present
	John M. Moore, MD, Lexington	Present	Present
	Dovid O'Reilly, MD, Lexington	Present	Present
	Gregory V. Osetinsky, MD, Lexington	Present	Present
	Borboro A. Phillips, MD, Lexington	Present	Present
	John W. Poundstone, MD, Lexington	Present	.....
	Mark Rukavino, MD, Lexington	Present	.....
	Not Sondler, MD, Lexington	.....	Present
	Suson E. Spires, MD, Lexington	Present	.....
	Dovid B. Stevens, MD, Lexington	Present	Present
	John D. Stewort, MD, Lexington	Present	Present
	Dole E. Toney, MD, Lexington	Present	Present
	Henry G. Wells, Jr, MD, Lexington	.....	Present
	John Robert White, MD, Lexington	Present	Present
	Emery A. Wilsan, MD, Lexington	Present	.....
	Eric C. Wilson, MD, Lexington	.....	Present
	Williom Witt, MD, Lexingtan	.....	.....
JESSAMINE			
WOODFORD			

ELEVENTH District

CLARK	Doniel Alan Ewen, MD, Winchester	.....	.....
ESTILL	John A. Potterson, MD, Irvine	.....	.....
LEE	Jomes B. Noble, MD, Beottyville	.....	.....
JACKSON			
MADISON			
MONTGOMERY			
MENIFEE			
OWSLEY			
POWELL	Chorles G. Noss, MD, Stonton	.....	.....
WOLFE			

TWELFTH DISTRICT

BOYLE	Brion Ellis, MD, Danville	.....	.....
	Arthur K. Rivord, MD, Donville	Present	Present
	Scott Scutchfield, MD, Donville	Present	.....
CASEY			
CLINTON	Michoel Cummings, MD, Albony	.....	.....
GARRARD	Poul J. Sides, MD, Loncoster	.....	Present
LINCOLN			
MCCREARY			
MERCER	George Noe, MD, Horrodsburg	.....	.....
PULASKI	Steven M. DeMunbrun, MD, Somerset	Present	.....
	Debro Eodens, MD, Somerset	Present	.....
	B. J. Porsons, MD, Somerset	Present	Present
	Jomes D. Wilson, MD, Somerset	.....	.....
ROCKCASTLE	Michoel Homilton, MD, Mt. Vernan	.....	.....
RUSSELL	H. Michoel Oghio, MD, Russell Springs	.....	.....
WAYNE	Edword Joseph, MD, Monticello	.....	.....

THIRTEENTH DISTRICT

BOYD	George Aitken, MD, Ashlond	.....	.....
	Mourice J. Ookley, MD, Ashlond	Present	Present
	Roger Potter, MD, Ashlond	Present	Present
	Susan Prasher, MD, Ashlond	Present	Present
	Charles Wotson, MD, Ashlond	Present	Present
CARTER			
ELLIOTT			
GREENUP	John O. Jones, MD, Flotwoods	Present	.....
	Monuol Gorcio, MD, Ashlond	.....	.....
LAWRENCE			
LEWIS			
MORGAN			
ROWAN	Jone Wiczkowski, MD, Moreheod	.....	Present

FOURTEENTH DISTRICT

BREATHITT			
FLOYD	Nicholos R. Jurich, MD, Prestonsburg	Present	Present
	Deboroh Holl, MD, Prestonsburg	.....	.....
LETCHER			
JOHNSON	Thomos A. Smith, MD, Pointsville	.....	.....
KNOTT			
MAGOFFIN			
MARTIN			
PERRY	Gilray Daley, MD, Hozord	Present	.....
	Syomalo Reddy, MD, Hozord	.....	Present
PIKE	Gregory Hozelett, DO, Pikeville	Present	Present
	Chorles Nichals, MD, Pikeville	Present	Present
	J. Steven Shockey, MD, Pikeville	Present	Present

FIFTEENTH DISTRICT

BELL	Fronk Moppolo, MD, Middlesbaro	.....	.....
	Emanuel Roder, MD, Middlesboro	.....	.....
CLAY	Iro F. Wheeler, MD, Manchester	.....	Present
HARLAN	Shoron Colton, MD, Evorts	Present	Present
	Sondford Weiler, MD, Harlan	.....	.....
KNOX	Horold Bushey, MD, Borbourville	.....	Present
LAUREL	Dovid Douglos, MD, Londan	.....	Present
	Williom D. Prott, MD, Landon	.....	.....
LESLIE			
WHITLEY	P. Bruce Borton, MD, Corbin	Present	Present
	Kothy Mortin, MD, Corbin	.....	.....
	Rod Weisert, MD, Carbin	.....	.....
	Trumon Perry, MD, Corbin	.....	Present

KMA Student Section

UL	Kote Wilson, Louisville	.....	.....
UK	LoDonya Reed, Lexington	.....	.....

KMA Resident Physicians Section

Kristen Cooper, MD, Modisonville		.....	.....

KMA Organized Medical Staff Section

John O'Brien, MD, Louisville		.....	.....

The informotion in the roll coll wos token from the ottendance record cords signed by the delegotes prior to the meetings of the House, September 21 ond September 23.

148th Annual Meeting

Kentucky Medical Association



Index to Proceedings and Reports

Minutes, House of Delegates First Meeting 525
Minutes, House of Delegates Second Meeting 528
Ad Hoc Committee on Faculty Membership 558
Ad Hoc Committee to Develop a Comprehensive School Health Education Plan 563
Ad Hoc Committee to Recommend a Section on International Medical Gradutates 564
Alliance, Report of the President 530
Board of Trustees, Chair 532
Board Meetings, Summary of 533
Cancer 542
Care for the Elderly 551
Changing Trends in Medicine, Committee to Investigate 557
Child and School Health 562
Community and Rural Health 562
Continuing Medical Education 541
Council for Continuing Medical Education 542
Delegates to AMA 535
Editor 535
Election of 1999 Nominating Committee 566
Election of Officers 566
Ephraim McDowell Cambus-Kenneth Foundation, Inc 538
Executive Vice President 536
Interspecialty Council 564
Judicial Council 563
KMA Physicians Plan, Inc 537
KEMPAC Report 555
Kentucky Medical Insurance Company 538
Maternal Mortality Study 552
Maternal and Neonatal Health 561
Medicaid Managed Care 556
Medical Insurance and Prepayment Plans 555
Medical Student Section 558
Membership Task Force 558
National Legislative Activities 546
Organized Medical Staff Section 543
Physical Education and Medical Aspects of Sports 562
Physician Advisory Committee to Health Kentucky 538
Physician Services (Medicaid), Technical Advisory 561
Physician Workforce 543
President 529
President-Elect 531
Professional Liability Insurance 551
Proposed Constitutional Amendment 528
Public Education 551
Resident Physicians Section 557
Rural Kentucky Medical Scholarship Fund 544
Scientific Exhibits 541
Scientific Program 541
Secretary-Treasurer 534
Speakers, House of Delegates 532
State Legislative Activities 547
Young Physicians Steering 557

Index to Resolutions

Resolution	Subject	
Tributes	Bob DeWeese, MD	527
	Nancy W. Dickey, MD	527
	William B. Monnig, MD	529
	Women in Medicine	527
Memorials	Krishan L. Arora, MD	525
	Ralph C. Morris, MD	525
	Debra L. Zukof, MD	526
98-101	Evaluation and Management Guidelines and Fraud & Abuse Investigation	552
98-102	Outcomes Indexed by Severity	559
98-103	Medicaid Outpatient Testing	564
98-104	Study of Current Antitrust Environment	553
98-105	KMA Annual Meeting Dates	539
98-106	Credentialing of Nuclear Medicine Technologies	544
98-107	Guidelines for Pap Smear Review in Litigation: KMA Endorsement for College of American Pathologists Guidelines	544
98-108	Patient-Physician Relationship	559
98-109	Physician Assistants	545
98-110	Confined Animal Feeding Operations (CAFOs)	564
98-111	Universal Health Care	559
98-112	Health System Reform	539
98-113	Managed Care	559
98-114	Membership Recruitment	560
98-115	Physician Education on End-of-Life Care	544
98-116	KMA Strategic Plan	539
98-117	Gag Clauses	553
98-118	Fraud and Abuse	554
98-119	Insurance Department Enforcement of Late Payment Statutes	560
98-120	Sessions of the Kentucky General Assembly	554
98-121	Observer Status for Kentucky Academy of Physician Assistants	540
98-122	Vaccine for Children (VFC)	565
98-123	Universal Vaccine	565
98-124	Physician Assistants	545

Reference Committees

Special appreciation to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee A: Samuel R. Scheen, III, MD, Louisville; Charles G. Nichols, MD, Pikeville; James R. Bean, MD, Lexington, Chair; Ted Miller, MD, Crestview Hills; Kate B. Wilsan, Lauisville, Medical Student Sectian. Nat pictured, Beverly M. Gaines, MD, Lauisville.



Reference Committee B: Susan H. Prasher, MD, Ashland; Billy Jae Parsan, MD, Samerset; Ranald E. Waldridge, MD, Shelbyville; Allan E. Hallquist, MD, Flarence; W. Lisle Daltan, MD, Lexington, Chair; Jannice O. Aaron, MD, Lauisville.



Reference Committee C: Gregory V. Hazelett, DO, Pikeville; Gilroy L. Daley, MD, Hazard; Deborah B. Mattingly, MD, Bardstown; James F. Beattie, Jr, MD, Bowling Green, Chair; Susan E. Spires, MD, Lexington; Mallay G. Veal, MD, Lauisville.



Reference Committee D: David T. Allen, MD, Lauisville; Jahn D. Stewart, II, MD, Lexingtan; Judy M. Linger, MD, Geargetawn, Chair; Rabert J. Emslie, MD, Bawling Green; David A. Watkins, MD, Hendersan. Nat pictured, Kirsten L. Coaper, MD, Madisonville.



Reference Committee E: Daniel E. Kenady, MD, Lexington; LaDonya Reed, Lexingtan, Medical Student Section; Scatt B. Scutchfield, MD, Danville; Jahn S. Cave, MD, Henderson, Chair; William P. McElwain, MD, Mt. Vernon; Barbara A. Phillips, MD, Lexington

The Milton Board, MD Memorial Meeting of the Kentucky Medical Association

Digest of Proceedings of the Regular Session of the

House of Delegates

John W. McClellan, MD, Henderson
Speaker of the House
Thomas K. Slabaugh, MD, Lexington
Vice Speaker of the House
Presiding

First Meeting
September 21, 1998

John W. McClellan, MD, Speaker of the KMA House of Delegates, called the first meeting of the 148th Session of the House of Delegates to order at 10:00 AM on Monday, September 21, 1998, at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced the Vice Speaker, Thomas K. Slabaugh, MD, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Harold L. Bushey, MD, Barbourville, gave the invocation. A motion was made, seconded, and carried to approve the Minutes of the 1997 Session of the House of Delegates as published in the December 1997 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:30 AM on Tuesday, September 22, and the President's Luncheon would be held on Wednesday, September 23, at which time the new President would be installed. Dr VonderHaar reminded the delegates that reference committees would convene at 1:00 PM on Monday. He then referred to three Memorial Resolutions submitted by the Jefferson County Medical Society for Krishan K. Arora, MD; Ralph C. Morris, MD; and Debra L. Zukof, MD; and a list of KMA members who had died since the 1997 meeting, and asked the House members to stand for a moment of silence in memory of all of these physicians.

Memorial to Krishan L. Arora, MD
Jefferson County Medical Society

WHEREAS, Krishan K. Arora, MD, was a native of Amritsar, India, and completed a fellowship in Nephrology at the University of Louisville following medical training in England; and

WHEREAS, Dr Arora was Board Certified in Internal Medicine and Nephrology, serving on the Active medical staff of Jewish Hospital in Louisville since 1975; and

WHEREAS, Dr Arora was senior partner of Nephrology Associates of Kentuckiana, was Medical Director of Fresenius Dialysis Center and previously had served on the faculty of the University of Louisville School of Medicine; and

WHEREAS, Dr Arora was a highly respected professional and a beloved colleague who demonstrated devotion to his family, his patients, showed respect and kindness to hospital staff and fellow professionals alike; and

WHEREAS, Dr Arora was tragically struck down by an unknown assailant June 22, 1998, in his Oldham County home, leaving an irreparable loss in the hearts and lives of Kentucky's medical community; now, therefore, be it

RESOLVED, that the Kentucky Medical Association express its deep regret to the family, friends, patients, and colleagues of Krishan K. Arora, MD; and be it further

RESOLVED, that the KMA encourage all who knew him to keep alive their fond memories of the caring human being and dedicated physician who was Krishan K. Arora, MD; and be it further

RESOLVED, that the House of Delegates observe a moment of silence in memory of Dr Arora, and that a copy of this resolution be forwarded to the family of Krishan K. Arora, MD, along with this Association's recognition of his lasting contribution to the health of Kentucky's citizens.

Memorial to Ralph C. Morris, MD
Jefferson County Medical Society

WHEREAS, Ralph C. Morris, MD, was a member of the Kentucky Medical Association and the Jefferson County Medical Society for 43 years, having been elected to membership in 1955 and having served in this House of Delegates for many years; and

WHEREAS, Dr Morris served as Second Vice President of the Jefferson County Medical Society in 1992-93, was a nominee for the office of President-Elect in 1988, and was elected to a three-year term on the JCMS Judicial Council in 1996, serving as Secretary of the council in 1997-98; and

WHEREAS, Dr Morris was well known and highly respected for his community service on behalf of African-Americans, having served on the West Louisville Health Education Center's advisory board where he worked to educate the community on health issues, including sickle-cell anemia and high blood pressure; and

WHEREAS, Dr Morris chaired the Jail Health and Civic Affairs Committees of the Jefferson County Medical Society, served on many other boards and committees, and provided effective leadership as a legislative key contact physician for many years; and

WHEREAS, Dr Morris, a former assistant clinical professor at the University of Louisville School of Medicine, President of the Red Cross Hospital medical

Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.

staff, and President of the Falls City Medical Society, died August 7, 1998, at age 76; now, therefore, be it

RESOLVED, that the Kentucky Medical Association observe a moment of silence in memory of Ralph C. Morris, MD, to honor his dedicated service as a physician, a community leader, and a fellow Delegate; and be it further

RESOLVED, that a copy of this resolution be forwarded to the family of Ralph C. Morris, MD, along with this Association's recognition of his lasting contribution to the health of Kentucky's citizens.

Memorial to Debra L. Zukof, MD
Jefferson County Medical Society

WHEREAS, Debra L. Zukof, MD, was a 1985 graduate of the University of Louisville School of Medicine and earned her board certification in psychiatry in 1991; was a staff member and former medical director at Ten Broeck Hospital in Louisville; and also was on the staff at Baptist Hospital East, where she monitored the quality of patient care in psychiatric and chemical-dependency cases; and

WHEREAS, Dr Zukof was dedicated to her practice and to her patients, maintaining the traditions of medical excellence modeled by her father, Martin Zukof, MD, and her uncle, Walter H. Zukof, MD; and

WHEREAS, Debra Zukof, MD, was the wife of Barry Willett, a former president of the Kentucky Academy of Trial Attorneys, and was the mother of a five-year-old son and a one-year-old daughter; and

WHEREAS, Dr Zukof was active in The Temple congregation and the Jewish Community Federation and in her medical professional societies, serving on the 1998-99 Jefferson County Medical Society Pictorial Roster Committee; and

WHEREAS, Dr Zukof lost her life on August 1, 1998, when the private plane in which she, her husband, and two friends were returning from Chicago crashed upon takeoff and sank into Lake Michigan; now, therefore, be it

RESOLVED, that KMA express to family, friends, and colleagues its profound sense of loss brought about by the untimely death of Debra Zukof, MD; and be it further

RESOLVED, that the Kentucky Medical Association honor the memory of Dr Zukof with a moment of silence by this House of Delegates; and be it further

RESOLVED, that a copy of this resolution be forwarded to the family of Debra L. Zukof, MD, along with this Association's recognition of her lasting contribution as a caring human being and as a dedicated physician.

Dr VonderHaar announced the initiation of KMA's Member-Get-A-Member campaign, and asked all delegates to participate by picking up their personalized recruitment kit.

Mrs Aroona Dave, Immediate Past President of the KMA Alliance, was asked to present the Alliance AMA Foundation checks to representatives from the University of Louisville School of Medicine and the University of Kentucky College of Medicine. Joining Mrs Dave at the podium to make these presentations was Carolyn Daley, who served as the KMAA Chair for the AMA Foundation during the past year.

Laura Schweitzer, PhD, Associate Dean of Faculty Affairs and Student Affairs accepted checks in the amount of $21,637.40 on behalf of the University of Louisville. Emery Wilson, MD, Dean of the College of Medicine, accepted checks in the amount of $16,828.00 on behalf of the University of Kentucky. Both expressed their appreciation for the donations, and noted that the funds would be used to enhance student activities and assist with scholarships and special programs.

Speaker McClellan then called upon C. Kenneth Peters, MD, President, to present the Educational Achievement Award to Gordon L. Hyde, MD, Lexington. Dr Hyde is Professor Emeritus of Surgery at the University of Kentucky College of Medicine, having served on the faculty there since 1963. In 1981 the residents established an award in his name for a faculty member contributing the most to the University of Kentucky Residency Program and honored him as the first recipient. Dr Hyde was twice recipient of the "Master Teacher Award" by the University of Kentucky in 1994 and 1995. Dr Hyde was honored for his influence on residents and medical students through his efforts in the areas of substance abuse, quality of patient care, medical education, and classroom and bedside teaching.

Speaker McClellan announced that each delegate's packet contained a booklet prepared by the Rules Committee outlining the rules the House should follow in its deliberations. He also noted that a list of reference committee members serving during the 1998 Annual Meeting had been distributed.

Dr McClellan then called upon Dr Peters to give the report of the President. Dr Peters noted that KMA had enjoyed a successful legislative year. He also reported on some innovative efforts, such as the regional trustee district meetings and the KMA Strategic Plan. He indicated that detailed information on the long-range planning session held at Shakertown in May of 1998 was presented in a book distributed to members of the House entitled *KMA Future Search*. He urged all delegates to review this material and use it as a road map for KMA's future.

Dr Peters also reported that regular meetings had been reinitiated between Anthem Blue Cross and Blue Shield leadership and the KMA Board of Trustees, and he hoped there would be an ongoing dialogue that would benefit the profession and patients. He also made special mention of the Healing Place, run for the past nine years by the Jefferson County Medical Society Outreach Program. The Healing Place provides emergency shelters for homeless men, women and children; sobering-up centers; and self-help recovery programs for alcoholics and addicts. The Healing Place was the recipient of the US Department of Health and Human Services "Models That Work" award. John Morse, Secretary of the Cabinet for Health Services, recently visited the center and pledged his support and that of the Patton Administration to assist with the establishment of similar programs throughout the state.

Following Dr Peter's report, Aroona Dave, Immediate Past President of the KMA Alliance, presented highlights from her written report. Mrs Dave reported that membership in the Alliance is strong, with over 1,000 volunteers working as KMA's proactive voice in the community. She drew particular attention to the 1997-98 SAVE Program (Stop America's Violence Everywhere). As part of this program 80,000 each of *Hands Are Not For Hitting* and *I Can Choose* booklets were distributed in twenty counties. She also reported on some of the other successful projects in which the Alliance had participated.

Dr McClellan introduced the other officers to present their reports. The reports of the Speakers and the Chair of the Board of Trustees were not read. Don R. Stephens, MD, President-Elect, summarized his report, indicating that this past year had been a learning experience for him, and that he plans to work toward the goals set for the future through the KMA Strategic Plan. Dr VonderHaar, Secretary-Treasurer, made brief remarks. Each of the officers' reports and all committee reports were assigned to a reference committee as noted:

Report Number		Reference Committee
1	Report of the President	A
2	Report of the President, KMA Alliance	A
3	Report of the President-Elect	A
4	Report of the Speakers, House of Delegates	A
5	Report of the Chair, Board of Trustees	A
6	Report of the Secretary-Treasurer	A
7	Report of the Editor	A
8	Report of the Delegates to AMA	A
9	Report of the Executive Vice President	A
10	Report of KMA Physicians Plan, Inc	A
11	Report of the Kentucky Medical Insurance Company	A
12	Ephraim McDowell Cambus-Kenneth Foundation	A
13	Report of Physician Advisory Committee to Health Kentucky	A
14	Scientific Program Committee	B
15	Scientific Exhibits Committee	B
16	Continuing Medical Education Committee	B
17	Council for Continuing Medical Education	B
18	Cancer Committee	B
19	Physician Workforce Committee	B
20	Organized Medical Staff Section	B
21	Rural Kentucky Medical Scholarship Fund	B
22	Maternal Mortality Study Committee	C
23	Committee on National Legislative Activities	C
24	Committee on State Legislative Activities	C
25	Committee on Professional Liability Insurance	C
26	Committee on Care of the Elderly	C
27	Public Education Committee	C
28	Committee on Medical Insurance and Prepayment Plans	D
29	Committee on Medicaid Managed Care	D
30	Committee to Investigate Changing Trends in Medicine	D
31	Young Physicians Steering Committee	D
32	Resident Physicians Section	D
33	Medical Student Section	D

	KMA Membership Task Force	D
	Ad Hoc Committee on Faculty Membership	D
34	Committee on Maternal and Neonatal Health	E
35	Technical Advisory Committee on Physician Services (Medicaid)	E
36	Committee on Community and Rural Health	E
37	Committee on Physical Education and Medical Aspects of Sports	E
38	Committee on Child and School Health	E
39	Judicial Council	E
40	Interspecialty Council	E
	Ad Hoc Committee to Develop a Comprehensive School Health Education Plan	E
	Ad Hoc Committee to Recommend a Section on International Medical Graduates	E

New Business

New Business of the House was assigned to the reference committee indicated:

Resolution	Submitted by	Subject	Reference Committee
101	Daviess County Medical Society	Evaluation & Management Guidelines and Fraud & Abuse Investigation	C
102	Jefferson County Medical Society	Outcomes Indexed by Severity	D
103	JCMS	Medicaid Outpatient Testing	E
104	JCMS	Study of Current Antitrust Environment	C
105	JCMS	KMA Annual Meeting Dates	A
106	JCMS	Credentialing of Nuclear Medicine Technologies	B
107	Fayette County Medical Society	Guidelines for Pap Smear Review in Litigation: KMA Endorsement for College of American Pathologists Guidelines	B
108	FCMS	Patient-Physician Relationship	D
109	McCracken County Medical Society	Physician Assistants	B
110	John A. Patterson, MD, MSPH	Confined Animal Feeding Operations (CAFOs)	E
111	FCMS	Universal Health Care	D
112	FCMS	Health System Reform	A
113	FCMS	Managed Care	D
114	Board of Trustees	Membership Recruitment	D
115	Board of Trustees	Physician Education on End-of-Life Care	B
116	Board of Trustees	KMA Strategic Plan	A
117	Board of Trustees	Gag Clauses	C
118	Board of Trustees	Fraud and Abuse	C
119	Board of Trustees	Insurance Department Enforcement of Late Payment Statutes	D
120	Board of Trustees	Sessions of the Kentucky General Assembly	C
121	Board of Trustees	Observer Status for Kentucky Academy of Physician Assistants	A
122	Board of Trustees	Vaccine for Children (VFC)	E
123	Board of Trustees	Universal Vaccine	E
124	Board of Trustees	Physician Assistants	B

Dr McClellan then turned the meeting over to Vice Speaker Slabaugh, who indicated that the House had received some late resolutions, the last of which was numbered 98-124. Three new "tribute" resolutions were introduced by the Board of Trustees. The first was entitled "Tribute to Bob M. Deweese, MD"; the second, "Tribute to Nancy W. Dickey, MD"; and the third, "Women in Medicine." As each resolution was read, a motion was made, seconded, and carried to adopt each as written.

Tribute to Bob M. DeWeese, MD
Board of Trustees

WHEREAS, Representative Bob M. DeWeese, MD, has served his constituents and profession with great honor; and

WHEREAS, Bob M. DeWeese, MD, introduced and cosponsored House Bill 315, which included the KMA House of Delegates Patient Protection /Provider Fairness provisions; and

WHEREAS, as a result of the leadership and tenacity of Representative Bob DeWeese, the 1998 Kentucky General Assembly adopted House Bill 315, which included patient protection provisions, the KMA House of Delegate's number one priority; and

WHEREAS, fellow legislators, lobbyists, and media named Bob M. DeWeese, MD, as one of the top 10 legislators in terms of leadership, character, and integrity; and

WHEREAS, Bob DeWeese, MD, has become known statewide as a proponent and advocate of patient rights and the physician/patient relationship; now, therefore, be it

RESOLVED, that the 1998 Kentucky Medical Association House of Delegates commends Bob M. DeWeese, MD, for his outstanding public service career; and be it further

RESOLVED, that this House of Delegates expresses its appreciation for his devotion to the profession; and be it further

RESOLVED, that Bob M. DeWeese, MD, be presented with a copy of this resolution; and be it further

RESOLVED, that this presentation be made a permanent part of the records of the 1998 House of Delegates.

Tribute to Nancy W. Dickey, MD
Board of Trustees

WHEREAS, Nancy W. Dickey, MD, has been at the forefront in promoting and supporting women's involvement in organized medicine; and

WHEREAS, Nancy W. Dickey, MD, has displayed outstanding leadership skills and character and through her devotion to patients and the profession, served as a role model for women physicians throughout the federation of medicine; and

WHEREAS, Nancy W. Dickey's distinguished career has included service as a member of the AMA House of Delegates and the AMA Board of Trustees, where she has served as Vice Chair and Chair; now, therefore, be it

RESOLVED, that the 1998 Kentucky Medical Association House of Delegates honors Nancy W. Dickey, MD, for her personal and professional accomplishments and commends her for her distinguished service and career; and be it further

RESOLVED, that the Kentucky Medical Association House of Delegates, on behalf of all Kentucky physicians, recognizes and applauds Nancy W. Dickey's unique accomplishment by becoming the first woman President of the American Medical Association; and be it further

RESOLVED, that Nancy W. Dickey, MD, be presented with a copy of this resolution, and that this resolution be made a permanent part of the 1998 House of Delegates records.

Women in Medicine
Board of Trustees

WHEREAS, September 1998 has been designated by the AMA as Women in Medicine Month; and

WHEREAS, just over 11% of physicians were women in 1980, but by 1996, women accounted for 22% of the total physician population; and

WHEREAS, women now represent more than 35% of all residents/fellows and 42% of all medical students; and

WHEREAS, more than 157,000 women physicians practice in the United States; and

WHEREAS, the Women Physicians Congress has been established as a grass roots forum for debate, support, mentoring, and input into AMA policy and programming decisions on important women's health and professional issues; and

WHEREAS, women comprise the federation's fastest growing membership segment; now, therefore, be it

RESOLVED, that the 1998 Kentucky Medical Association House of Delegates offers special tribute to Kentucky's women physicians; and be it further

RESOLVED, that the Kentucky Medical Association notes with pride the election of Ardis D. Hoven, MD, who served this Association in 1994-95 as KMA's first woman President; and be it further

RESOLVED, that Nancy W. Dickey, MD, first woman President of the AMA, is commended and honored by this House of Delegates for her outstanding accomplishments in the field of medicine; and be it further

RESOLVED, that women physicians are urged to become more involved in the leadership of medicine and participate in all levels of the federation; and be it further

RESOLVED, that the House of Delegates urges the KMA Board of Trustees to continue appointing women to crucial leadership and other policy-making positions; and be it further

RESOLVED, that women physicians interested in "women in medicine" issues are urged to join and participate in the Women Physicians Congress.

Vice Speaker Slabaugh announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. These meetings will take place at the close of the House meeting. He indicated which districts would be meeting and read the list of counties falling within those districts. Dr Slabaugh then reminded the delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning, and noted that the nominations would be read Wednesday night and additional nominations could be made from the floor at that time.

The names of the Nominating Committee members were announced: Susan M. Berberich, MD, Louisville, Chair; John S. Cave, MD, Henderson; Dennis B. Kelly, MD, Lexington; Lucian Y. Moreman, MD, Elizabethtown; and Mary Jo Ratliff, MD, Pikeville.

Vice Speaker Slabaugh reported that in August AMA asked if KMA would participate in a national "Patient Bill of Rights" meeting with the President of the United States. President Clinton came to Louisville on August 10 and requested that the President of KMA present the KMA/AMA position on Patient Protection. The House then viewed a brief video of that presentation.

Greg Cooper, MD, was called to the podium to make a presentation to Dr Peters on behalf of the Association. Dr Peters was presented with a framed photograph taken as he made his address during the presidential visit.

President Peters then introduced AMA President Nancy W. Dickey, MD, who made a presentation to the House of Delegates.

Dr Dickey discussed some of the special programs at AMA. She noted that the American Medical Accreditation Program, or AMAP, was established to ensure that peers would be setting the standards in medicine and measuring their effectiveness. The program includes credentialing, quality of care review, etc. AMAP is now in place in several states, and she expressed the hope that it would eventually replace some of the outside intrusion into the physician's office.

Dr Dickey also discussed the National Patient Safety Foundation. She noted that there are a substantial number of mistakes made in medicine. This program attempts to identify those that are preventable and take steps to improve patient safety. This is a not-for-profit foundation that brings representatives from many different groups together. She noted that the foundation has been operating for over a year, is still conducting research, and now has a web site.

Dr Dickey also addressed the E & M codes. She noted that appropriate documentation enhances quality of care, but too many of the codes are not functional. The 1997 guidelines were withdrawn, and AMA is negotiating with HCFA about new ones. The AMA has asked that no enumeration or counting of any kind be used. HCFA has indicated there will be some, but has agreed to work with medicine to redraft these. Dr Dickey reported that by early 1999 the new guidelines should be redrafted, and pilot testing will take place, which should identify any glaring errors. Early in 2000 the guidelines will come out. Dr Dickey cautioned delegates that although the 1997 guidelines are no longer mandated, the audit process is still in operation, and the doctor's office must meet either the 1995 or 1997 guidelines.

Dr Dickey next discussed fraud and abuse. She noted that the AMA took exception to the assumption that there is significant misuse of Medicare dollars by physicians. HCFA must be able to prove there was knowing and willful intent, and that the event represents a pattern of repeat behavior. HCFA should notify the physician of the infraction and allow that physician to change the behavior being questioned. HCFA is also being asked to change the Explanation of Benefits statement, which now implies the doctor did not provide needed care. The AMA hopes to identify ads and language in Explanation of Benefits statements that are misleading.

Dr Dickey stated that the AMA is working for appropriate legislation on the national level to support patient rights. The Kentucky patient rights legislation must be protected, as well as that passed in Texas. She pointed out that there is the chance that an unfavorable federal bill could negate what has been done on the state level.

Dr Dickey also reviewed AMA's Private Sector Advocacy Program. Under this program, a team consisting of a lawyer, public relations expert, and AMA officer will help in local contract negotiation. The program is designed to help the physician make the best of the current environment. She noted that Aetna has recently agreed to send its own team out to meet with dissatisfied doctors about their contracts.

Dr Dickey stated that the AMA does want to insure choice. The system should also allow individual choice. She noted that there are still many people who are uninsured or underinsured, but some of these groups would be fairly easy to cover, for example college students. She also felt that some that qualify for Medicaid have not applied because there are too many hurdles to enrollment. She felt all physicians should work together to assure access to care.

Dr Dickey concluded by expressing the need for doctors to be in the lead in reforming the system so that it is just the patient and the doctor in the examining room, rather than a bureaucrat.

The Speaker adjourned the First Meeting at 11:30 AM.

Second Meeting
September 23, 1998

John W. McClellan, MD, Speaker, House of Delegates, called the Second Meeting of the 1998 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, September 23, 1998.

Barbara Phillips, MD, Lexington, gave the invocation, and David Zoeller, MD, Elizabethtown, Chair of the Credentials Committee, reported that a quorum was present.

Dr McClellan explained the composition of the House of Delegates and indicated those who had voting privileges.

Members of the House were reminded that a proposed amendment to the Constitution and Bylaws had been presented to the House of Delegates last year and mailed to all delegates for a vote this year. The amendment would allow the Dean of the University of Kentucky College of Medicine and the Dean of the University of Louisville School of Medicine to have designated delegate status in the House of Delegates with voting privileges, as well as provide for representation from the Resident Physicians Section, the Medical Student Section, and the Organized Medical Staff Section of the KMA. The amendment must be approved by a two-thirds vote.

A motion, was made, seconded, and carried to adopt the constitutional amendment.

PROPOSED CONSTITUTIONAL AMENDMENT

Article VI, Section 2:

Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. ~~Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex officio members of the House of Delegates and entitled to vote.~~ ***[The following members shall be designated as ex-officio members of the House of Delegates of the Kentucky Medical Association and entitled to vote: Officers of the Association, Delegates and Alternate Delegates of the American Medical Association, and five immediate Past Presidents; the Dean of the University of Kentucky College of Medicine; the Dean of the University of Louisville School of Medicine; a representative of the Resident Physician's Section of the Kentucky Medical Association; a student representative of each medical school of Kentucky; and a representative of the Organized Medical Staff Section of the Kentucky Medical Association.]*** All other Past Presidents and Vice Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Dr McCellan noted that the Board of Trustees had introduced a second amendment to the Constitution, which was being presented to the House of Delegates this year for approval by the 1999 House of Delegates. The amendment proposed for 1999 would designate the Dean of the Pikeville College School of Osteopathic Medicine as an ex-officio member of the House. This proposal was distributed to members of the House and will be sent to each county medical society at least two months prior to the 1999 KMA House of Delegates, at which time it must be approved by a two-thirds vote.

PROPOSED CONSTITUTIONAL AMENDMENT - 1999

Article VI, Section 2:

Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. The following members

shall be designated as ex-officio members of the House of Delegates of the Kentucky Medical Association and entitled to vote: Officers of the Association, Delegates and Alternate Delegates of the American Medical Association, and five immediate Past Presidents; the Dean of the University of Kentucky College of Medicine; the Dean of the University of Louisville School of Medicine; ***the Dean of the Pikeville College School of Osteopathic Medicine;*** a representative of the Resident Physician's Section of the Kentucky Medical Association; a student representative of each medical school of Kentucky; and a representative of the Organized Medical Staff Section of the Kentucky Medical Association. All other Past Presidents and Vice Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. These included Barney R. Maynard, MD, President of the Indiana State Medical Association; Carol S. Shapiro, MD, President of the Medical Society of Virginia; Lance Talmage, MD, President of the Ohio State Medical Association; Clair M. Callan, MD, President-Elect of the Illinois State Medical Society; David W. Avery, MD, President of the West Virginia State Medical Association; and Stephen Vilmer, MD, President of the Missouri State Medical Association. Also recognized was Nancy Kintzel, an AMA Field Services representative.

It was announced that a new tribute resolution was introduced by the Board of Trustees honoring William B. Monnig, MD, for his dedication and service to his profession, the Association, and particularly to KEMPAC. The resolution was read, and a motion was made, seconded, and carried to adopt it.

William B. Monnig, MD
Board of Trustees

WHEREAS, William B. Monnig, MD, has served this Association as Delegate, Trustee, Vice President, three terms as Chair of the Board, President, and Alternate Delegate to the AMA; and

WHEREAS, William B. Monnig, MD, has served as a member of the KEMPAC Board of Directors for six years; and

WHEREAS, William B. Monnig, MD, has served with distinction as Chair of the KEMPAC Board of Directors for two terms; and

WHEREAS, under his leadership KEMPAC has met and exceeded its membership goals and has been nationally recognized as one of the top political action committees in the United States; now, therefore, be it

RESOLVED, that the 1998 Kentucky Medical Association House of Delegates recognizes and honors Dr Monnig for his devotion to his profession and to this Association; and be it further

RESOLVED, that William B. Monnig, MD, be presented a copy of this resolution, and that this resolution be made a permanent part of the 1998 House of Delegates proceedings.

The Speaker then turned the proceedings over to Vice Speaker Slabaugh, who explained the proceedings for considering reference committee reports. He then called for reference committee chairs to present their reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE A

James R. Bean, MD, Lexington, Chair

1. Report of the President
2. Report of the President, Alliance
3. Report of the President-Elect
4. Report of the Speakers, House of Delegates
5. Report of the Chair, Board of Trustees
6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President
10. Report of KMA Physicians Plan, Inc
11. Report of the Kentucky Medical Insurance Company
12. Report of the EMCK Foundation
13. Report of the Physician Advisory Committee to Health Kentucky
    Resolution 105 — KMA Annual Meeting Dates
    (Jefferson County Medical Society)
    Resolution 112 — Health System Reform
    (Fayette County Medical Society)
    Resolution 116 — KMA Strategic Plan
    (Board of Trustees)
    Resolution 121 — Observer Status for Kentucky Academy of Physician Assistants
    (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee A reviewed the following items and recommends they be filed, by consent of the House, without discussion:

1. Report of the President — filed
2. Report of the President, Alliance — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chair, Board of Trustees — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
10. Report of KMA Physicians Plan, Inc — filed
11. Report of the Kentucky Medical Insurance Company — filed
12. Report of the EMCK Foundation — filed

Reference Committee A would like to express its appreciation to the authors of the reports which have been filed for their time and energy expended in preparing these reports for the House of Delegates. Reference Committee A recommends Adoption of the Consent Calendar as a whole.

Report of the President

As the Association year draws to a close and my truly exciting time as your President ends, I'd like to reflect on some of the memorable events that have occurred.

My overwhelming impression relates to the membership—a group of individuals, but all with the same goals and aspirations—all of you. My faith in physicians is renewed as I recall countless acts and situations where you—physicians—have continued to make a difference.

Likewise, I have been overwhelmed by the many kindnesses shown me through the year by so many of you. These feelings of acceptance and support have helped me to represent you with gratitude and honor. From sharing the stage with the President of the AMA and, later, with the President of the United States, to sharing a few moments with a colleague in his or her hometown, I have cherished the opportunities I've had to be your spokesman.

At the AMA Annual Meeting, I shared the dais with the presidents of 49 other states for the inauguration of Nancy W. Dickey, MD, the first female President of the AMA. Notwithstanding her stellar capabilities and experience, Dr Dickey embodies the new face of medicine and is another milestone in our recognition of the strength of our diversity. Of equal gratification to me is Dr Dickey's gracious acceptance of our invitation to address the KMA House of Delegates. To commemorate her visit and show KMA's support for all female physicians, a special reception has been planned for Dr Dickey and her women colleagues in Kentucky.

As your representative, I was honored to share the stage this year in our state with the President of the United States. In August, when congressional discussions about patient protection legislation were intense, I received a call from both the White House and the AMA requesting that I be on a program with the President to support the Administration's bill. This presentation took place on August 10 in Louisville, and was the pinnacle of my representation of the Association, as the event was carried by local media and, perhaps, nationally. [Editor's Note: Dr Peters' remarks for that meeting are printed in the September issue of the KMA *Journal.*]

This was a true hallmark because it represented the efforts of the AMA and the KMA in both state and national arenas on legislative mandates to protect patients' rights under managed care. Even though more than 30 states, including Kentucky, have adopted some sort of patient protection legislation, federal law provides immunity to HMOs and self-insured plans and gives them

special protection from state law. KMA's national efforts included a focused campaign to gain support from Kentucky's congressional delegation, a special trip to Washington to meet with Republican congressmen, and meetings by various members of the KMA leadership with Kentucky congressmen and congressional candidates in their districts.

At the state level, our efforts to obtain patient protection legislation were notably successful with the passage of House Bill 315. Sponsored by Representative Bob M. DeWeese, MD, and Representative Bob Damron, this bill received support from the Patton Administration and was ultimately adopted by the General Assembly.

These efforts at the national and state level have spotlighted a crucial issue that needs to be addressed regarding partisan politics. Many physicians traditionally have supported the Republican Party, and that party quite often reciprocated when it was in the minority. However, since attaining majority status at the national level and becoming nearly equal with Democrats in the state, the general recognition by the Republican Party of the goals of medicine has seriously diminished.

The 1997 Congressional Budget Act included increases in reimbursement for chiropractors, optometrists, nurse practitioners, and physician assistants, but provided for a significant reduction in reimbursement to physicians. The standing Congress also passed "fraud and abuse" laws that appear to be blatantly punitive in their enforcement mechanisms. During the 1997 special session and 1998 regular session of the Kentucky General Assembly, Republicans as a group did not support the patient protection legislation. In both these arenas Republicans appeared to be choosing to side with managed care and insurance companies over patients. To summarize this matter, physicians must support legislators and candidates for the legislature solely on their measurable support on issues, rather than on party affiliation. As a group, physicians should have no politics but furthering our goals as a profession.

Another significant effort that began this year was the development of a strategic plan. Several individuals gathered in Shakertown in May to develop a road map for the Association's future. As medicine continues to undergo dramatic transition, KMA must prepare itself for change and manage the future, rather than getting caught in the past. We must assure the relevance of KMA as the core of the profession in our state.

The strategic planning process required intense involvement and demanded a tremendous amount of personal dedication by members of the planning committee. The planning group consisted of physicians representing the continuum of individuals in our state, to include representation by age, sex, race, practice locale, and practice type. In addition, outside opinions were sought from leaders in the political, labor, business, and education communities. To help coordinate this effort, a consulting firm was selected to moderate the planning session and help direct us to accomplish our goals. The product of this effort provides a road map for the Association and gives some conclusive direction. During this meeting, the House will be asked to consider and support this effort formally.

As an adjunct to this process, the House will also be urged to adopt a peer-to-peer membership campaign. The future success of our profession will be proportionate to the level of individual participation we achieve.

In closing, allow me to express heartfelt thanks to the Board of Trustees, the membership, and staff for your outstanding support this year. We have enjoyed an excellent year and made great progress. My successor and classmate, Don Stephens, will be an outstanding President. Dr Stephens has been involved in all of the decisions made this year and is extremely well prepared to take the helm. Finally, Rhoda and I sincerely thank the membership for your encouragement and backing. We would be remiss if we didn't give special thanks to our Jefferson County Medical Society colleagues who supported us throughout a long career and provided the opportunity to serve as President of this great organization.

C. Kenneth Peters, MD
President

Report of the President, Alliance

The Alliance Story, which I began telling almost a year ago, has grown. It includes what we do. We are a statewide volunteer organization of over 1,115 caring physicians' spouses who serve as the proactive volunteer voices of the Kentucky Medical Association, promoting good health, working in coalition with other organizations.

The story is of a visionary approach supporting the family of medicine and working in coalition with other organizations for Focus '97-'98, where we integrated 'SAVE,' Stop America's Violence Everywhere, into a membership development tool. As a result, we have the newly organized **Madison County Medical Society Alliance**. There is strength in numbers, and we are 1,115 members strong. We increased by 24% over the previous year, far exceeding our goal of a 7.5% increase, and we earned an additional delegate to the AMAA convention. Our membership brochures carry a message from the AMAA President, Johnnie Amonette.

Dr Percy Wootten, 1997 AMA President; Dr Kenneth Peters; AMA's Mr Extinguisher; Ann Faris; and Molly O'Krafka helped us tell our story over and over again. Through SAVE, zero tolerance to violence was shown. Can we change violent behavior? Yes, we can, if we get very early to our children and propose alternatives to the violent behavior. The goals of the program are:

- **To honor the purpose of the National SAVE Program to Stop America's Violence Everywhere.**
- **To integrate SAVE Health Promotion, a visionary approach as a membership development tool.**
- **To work in coalition with other organizations.**
- **To reach out to 80,000 kindergarten through third-grade children (K-3) to plant alternatives to violence in conflict resolution in all the organized counties and some unorganized counties.**

A coalition was formed of the following groups:

- **Kentucky Medical Association, Public Education Committee**
- **Kentucky Cabinet for Health Services, Department for Public Health, Frankfort**
- **Trover Foundation**
- **Pike County Domestic Violence Board**
- **Southern Medical Association Auxiliary, Health Education**
- **Donation to Honor State Kentucky PTA Volunteers ("Where Children Come First")**
- **Perry County**
- **Donation to Honor KMA Alliance Volunteers Working in Coalition with the Organization for Quality Health Care of Children & Families Across the Commonwealth**
- **AMA Alliance by giving a discount**
- **All Organized County Alliances**

Through the above coalition, $23,000 was raised for 80,000 copies each of "I Can Choose" coloring books and "Hands Are Not For Hitting" placemats, and for a media violence seminar at the convention.

The Alliance is the winner of the Kentucky Association for School Health Award. Its Focus '97-'98 SAVE project distributed "Hands Are Not For Hitting" placemats and "I Can Choose" coloring books in kindergarten through third grade in 317 public schools in the following 27 counties: Daviess, Hopkins, Henderson, Warren, Jefferson, Fayette, Boyd, McCracken, Perry, Pulaski, Northern Kentucky, Webster, Caldwell, Crittenden, Todd, Trigg, Christian, Muhlenberg, Ohio, Union, McClean, Madison, Pike, Franklin, and Harrison.

An anti-tobacco resolution was introduced under the capable expert advice from the KMA legislative body and Mr Don Chasteen. Nine county presidents-elect and the resident physician spouses' president attended the AMA Alliance Confluence I and II. AMA-ERF (American Medical Association Education Research Foundation) checks for the following amounts are being sent to the University of Louisville and the University of Kentucky Student Assistance Fund: U of L $14,586-90, U of K $12,250-50; Excellence Fund: U of L $7,050, U of K $4,575.50. The KMA Alliance Scholarship Fund, which was established in the previous year (1996-97), is in the following amounts—U of K is $10,000, U of L is $6,300. The AMA Alliance 1998 fundraiser consists of Norman Rockwell "Doctor and a Doll" all-purpose cards (4/$100 and 1/$25). Carolyn Daley, Vice President, and all county chairs have done a good job. A significant increase in membership was shown in the following counties who were recipients of the AMA Alliance Membership Award: Daviess, Jefferson, Hopkins, Fayette, Warren and McCracken.

McCracken, Jefferson, Warren and Hopkins counties entered their health promotion projects to the AMA Alliance's Health Awareness Promotion Awards (HAP Awards) and they were recognized. Madison County Medical Society Alliance was recognized as the newly organized county.

Jefferson County public schools K-3 children were reached by Health Promotion School of Excellence and Dr Victoria Moore, County Health Services at the Health Departments. Jefferson County taught 102 SMART

(Students Made Aware Reject Tobacco) programs and raised funds for the Healing Place.

McCracken County has a scholarship program. Perry County has a "Growing Healthy" program in the schools. Boyd County raised funds for AMA's Foundation.

SMART programs were held in Jefferson, Daviess, McCracken and Fayette counties. Warren County's "Kids On The Block" program has been very successful. Hopkins County distributed crisis cards to every student in 4th-12th grades.

The following counties reported, according to the Department of Health Services:

Children from Hanson Elementary in Hopkins County are already learning from June Kubach, Director of the Family Advocacy Center; and from Linda Sedlak, the President of the Hopkins County Medical Alliance, on how to take care of any conflicting situation that arises. Counselors are going to expand this program into the whole semester.

Sandi Barbour, of the Green River Health Department, says the school counselors and teachers are thankful to receive "Hands Are Not For Hitting" placemats and "I Can Choose" coloring books. According to Dr Victoria Moore and Bonnie Ciarroccki of the Jefferson County Health Department, the SAVE program summons the best of all of us, including children who are receiving the materials.

Fayette County President Donna Rogers is working with Alliance members, local health departments, and family resource/youth centers to incorporate these two educational materials in the school curriculum this summer.

Northern Kentucky children will be taught about conflict resolution using these excellent materials through the DARE Program. Ann Gilbert, President of Perry County, has distributed these to K-3 children with the FOCUS '97-'98 SAVE—the members' purpose was to work in coalition with other organizations and inform them of what we do.

At the Madison County Medical Society Alliance, our newly formed county alliance officers are teaching their children about conflict resolution.

McCracken, Boyd and Pulaski County Alliances are working with school counselors and local health departments.

Across the state, the success of SAVE programs and activities has come from our members' hard work, commitment and unity to really make it happen. Alliance members are working hand-in-hand with school guidance counselors and health coordinators from local health departments, teachers, and family resource/youth centers.

Our mission this year has been to work with the Kentucky Medical Association, AMA Alliance, and other organizations in addressing the health needs of children and families and to inform the community about **"what we do."**

Mr President, the strength in the power of one to make a difference has been demonstrated in our membership, and is demonstrated all across the state in the following people: Winnie Mitchell and Ellen Kessler, of the Madison County Medical Society Alliance, to form our newly organized Alliance and have the SAVE project in place.

Carolyn Daley, our President-Elect, is to establish student scholarship funds at both the medical schools for AMA's Foundation.

Kentucky is represented on the AMA Alliance by Immediate Past President, Aroona Dave, who was elected by the House of Delegates to the Nominating Committee and Bylaws Reference Committee. A recommendation was made to our future presidents and board members to have a Board retreat and strategic planning session while we prepare for the next century.

It has been a real pleasure working with supportive and professional staff at the Kentucky Medical Association and AMA Alliance. Without their expertise and, Mr President, your guidance, this president would not have been as productive as we have been this year!

I shall treasure all my friends and friendship. It has been a real pleasure serving the Kentucky Medical Association Alliance.

Our story resounded in the Commonwealth of Kentucky when, upon request, Governor Patton signed a proclamation declaring October 8, 1997, "SAVE" Day, and when the Alliance was represented on the Governor's Council for Substance Abuse Kentucky Incentive Project.

Our SAVE Project received an award from the Kentucky Association for School Health.

Ann Hansen came to celebrate with us the 75 Years of Excellence. Newly installed President Jan Crase will continue the Alliance Story into the next year.

Mr Bill Applegate, Mr Bob Klinglesmith, and Ms Diane Maxey have been pillars of strength for the Alliance. Sue Tharp's professionalism and Jean Wayne's efficiency have helped the Alliance immensely this year!

Mr President, it has been a real pleasure and privilege to merge all in one true story—our story.

Aroona Dave
President

Report of the President-Elect

I have been honored this year to serve as your President-Elect and look forward, with some anxiety, to serving you and meeting the challenges of our Association as your President. I feel honored because of the grand tradition of this Association and the medical profession in which I have been allowed to take part. In this capacity, I have had the opportunity to observe all facets of KMA and, particularly, the efforts of the KMA leadership and staff in action. This has been an extremely gratifying episode in my life, and it is gratifying to report to you how involved and effective your Association is in its operations.

My years of service to this point and my observations this past year have helped me to focus on some areas that I hope to emphasize during the coming year. The major area of attention that I think KMA needs to continue is participation by all physicians and coordination of our efforts on behalf of medicine and the patients we serve—in a word, "unification" of the principles, ideas and efforts that are the bedrock of medicine and are the grounding of the oath I took so many years ago when I entered this profession.

Managed care, governmental intrusion, insurance carrier demands, the change in demographics of society and of our profession—all of these influences have divisive effects, regardless of our good intentions. All these influences constitute an even greater motivation for physicians, collectively, to maintain our focus on our science, our integrity, and our compassion for our patients.

The current popular cultural emphasis is on diversification. Indeed, we are all different from one another, but this diversification and the negative influences mentioned can work against unity. Unity comes from recognizing our differences as individuals and in theories, but focusing on our similarities. Our prime similarity is medicine.

To reinforce this similarity, I hope we can continue some of our efforts and begin some new ones that will function productively through the participation of us all. President Ken Peters initiated a strategic planning process this year, in which it was my privilege to participate. Through an intensive period of review of the current state of medicine and our Association, a number of areas were identified that constitute current and future needs of physicians. This was an illuminating and enlightening process, and it laid the groundwork for what I hope will be an ongoing work product of KMA. It is my intent to pursue the ideas developed through this strategic planning and continue the course that has been set for our ongoing growth and evolution as a profession and an Association.

On a more obvious level, KMA should continue its aggressive involvement in patient protection activities and legislation. There has been some dissension about which political party should lead the effort to accomplish patient protection mandates, and this is unfortunate. It seems only logical to me that we should neither support nor oppose everything either political party does. Instead, we should simply support those things that are right and oppose those things that are wrong. It seems apparent that in the political arena, as in all walks of life, we should give our approval to those issues that foster the welfare of our patients and our profession. Our support should be for issues, not individuals or parties. We shouldn't be against everything that elected officials do, only those things that they do wrong.

As another step in seeking to promote participation and involvement, the House of Delegates will be asked to support a program called "Member-Get-A-Member." This program is an extension of an effort adopted by the House of Delegates of the American Medical Association. It is my hope that the House will accept this proposal and, more importantly, that each member of KMA will make a personal commitment to work for the involvement of another physician. I am convinced that every issue addressed to this point can be satisfactorily resolved if every physician is actively involved. Our obligation to medicine does not end at the office or operating room door; it extends

through our Association to our patients and the public, and it requires everyone to take a part.

It is my privilege to continue the time-honored customs of the office of President. I am humbled by the responsibility and honored by the faith and confidence you have shown in me by electing me. I pledge my deepest efforts on your behalf.

Donald R. Stephens, MD
President-Elect

Report of the Speakers, House of Delegates

Your Speakers would like to cordially welcome you to the 148th Annual Meeting of the Kentucky Medical Association. This year the meeting memorializes Milton Board, MD (1870-1950). We hope that you bring the concerns and confidence of your constituents and county medical societies, and we pledge that all delegates and concerns will be heard.

Maintaining the traditional format of the meeting, the first session of the House will convene at 10:00 AM on Monday, the 21st of September, and the second and final session will convene at 7:00 PM, on Wednesday, September 23. We urge all delegates to attend both sessions of the House of Delegates as well as meetings of reference committees. Reference committees will convene beginning at 1:00 PM on Monday afternoon, September 21.

At the second meeting of the House officers will be elected. Positions to be filled are President-Elect, Vice President, Speaker, and Vice Speaker of the House of Delegates. In addition, the House will elect Delegates and Alternate Delegates to the American Medical Association, and Trustees from Districts 1, 3, 4, 12, and 14. Alternate Trustees from each of these districts will also be elected. The Nominating Committee of the Association will meet immediately following the end of the first session of the House on Monday, September 21. Announcements at the meeting will give the location for the Nominating Committee meeting.

Your Speakers would like to call your attention to a proposed change to the KMA Constitution, which was mailed to all county medical societies approximately 60 days ago. This change was proposed at the 1997 Annual Meeting, and in accordance with our governing documents, is laid over for a vote at the upcoming meeting. The proposed change would make the deans of the two medical schools in the state voting delegates of the House, and would also provide for positions for medical students from all of the medical schools in the state.

At this years' meeting we are pleased to welcome the current President of the American Medical Association, Nancy W. Dickey, MD. Dr Dickey will preside at a special reception for female physicians on Sunday afternoon, September 20, from 3:00 to 5:00 PM, and will address the House of Delegates at its opening meeting on Monday morning. Dr Dickey is a most capable and talented advocate for our profession, and is the first female President of the AMA. We are honored that she has arranged to be present at our meeting.

The future of our Association rests with our new and future members and leaders. We hope that each delegate will urge young physicians in their areas to attend the meetings, and would like to note that the KMA Young Physicians Section will hold a luncheon at noon on Tuesday, September 22. In addition, the Medical Student Section and the Resident Physician Section will hold their annual meeting at 1:00 PM on Tuesday, September 22. Please see other promotional materials on the meeting for exact locations.

Your Speakers will be available to any delegate or member throughout the meeting who may have questions, comments, or need advice on any issue relating to the House of Delegates. We welcome your contact.

Your Speakers appreciate the trust placed in them by this House of Delegates by electing us and allowing us to serve you. We commit every possible effort to helping to make this meeting informative and productive.

John W. McClellan, MD
Speaker, House of Delegates

Thomas K. Slabaugh, MD
Vice Speaker, House of Delegates

Report of the Chair, Board of Trustees

The challenges to KMA and the profession today are plentiful. My task is to outline some of the more formidable issues KMA faced over the past year, as well as give an overview of the significant amount of work carried out on your behalf by KMA's volunteer committees and staff.

Since 1998 was a legislative year, the Legislative Quick Action Committee held weekly meetings in Frankfort to assess new legislation, evaluate our position on active legislation and develop strategy in light of the changes, which occur frequently in the course of a legislative session. Your officers and Legislative Chair, Wally O. Montgomery, MD, were diligent in their attendance and dedication to the passage of legislation in the best interests of our patients and our members. I especially appreciate the commitment of Wally Montgomery who drives from Paducah to Frankfort every week to chair our meetings. He is always available to our lobbyists and staff, as well as to individual members, and spends a significant amount of time and effort on behalf of medicine. KMA is fortunate that he is willing to give so freely of his expertise and time.

Medicaid managed care was a major issue during the session with rumors that efforts would be made to derail the program all together. Legislation was introduced that essentially mirrored the policy of KMA, calling for a moratorium on the establishment of other regional programs until the experiences with Regions 3 and 5 demonstrated that their approach was superior to the kneecap program. A meeting was held with Governor Patton, Secretary Morse, and other cabinet members to discuss Medicaid, and KMA's position was made clear to the Administration. In the end, the Governor prevailed. However, it is not clear at the present time if the Administration's approach to Medicaid will become reality across the entire state. We continue to hear reports of financial losses by the programs already operating, as well as indications that other regions are reluctant to undertake risk-bearing agreements without increased financial participation by the state.

Patient protection legislation was enacted in Kentucky this year as a part of HB 315, the Insurance Reform Act. KMA is particularly grateful to Past President Bob DeWeese, MD, who serves in the House of Representatives, for his leadership role in shepherding the patient protection part of the bill through the legislative process. Dr DeWeese is highly regarded by members of the Kentucky General Assembly. The General Assembly enacted insurance reform as the result of carriers leaving the state as the result of provisions included in HB 250, championed by the Jones administration. Most of the "Jones era" big government legislation has now been repealed, but the turmoil created by their enactment may continue for years.

Advocates of alternative therapies were aggressive during this session. There were measures offered on a variety of therapies which are being monitored by the Ad Hoc Committee on Complementary and Alternative Therapies. This will continue to be a major issue.

The law requiring a Certificate of Need for the addition or expansion of facilities and services in excess of a certain monetary threshold was enacted and expanded over the years. Physicians' offices are exempt from CON unless the cost of the equipment or facility exceeds $1.5 million. This exemption is constantly under attack by some hospitals, fearing the movement of services from a hospital setting to an outpatient setting, especially those operated by physicians. This is particularly true of small hospitals with marginal financial resources. However, several states have repealed their CON laws with little or no negative results. We are meeting with KHA officers to continue discussing this matter.

Nationally, AMA is taking a strong leadership role in trying to enact a Patient Protection Plan that will hold ERISA-exempt payers accountable when they refuse or withhold necessary treatments and the patient is ultimately harmed. The KMA House of Delegates designated patient protection/provider fairness as a primary legislative goal. KMA was successful in passing Patient Protection legislation in the 1998 General Assembly, but it does not include the accountability provision.

President Peters led us through a strategic planning process last spring. A report has been written which outlines ten major general goals, which will be brought before the House for consideration. If adopted by the House, the Board of Trustees will oversee the development of an action plan based on specific ideas, suggestions, and recommendations coming out of the planning session. As a participant in that process, I believe it will be useful to the Association for years to come, and commend Dr Peters for his foresight and gentle guidance in getting this process underway.

As physicians across the state are faced with the demands of managed care, they look to KMA for guidance through the wilderness of unfamiliar terms and practices. KMA offered several seminars on contract review,

corporate compliance, fraud and abuse statutes, sexual harassment, and practice management. More are planned for the coming year. KMA was designated as the accreditor of CME courses on domestic violence. KMA not only accredited other programs; it presented several seminars and developed a videotape that meets the requirement for CME units. The tape has been well received by out-of-state physicians that maintain a license in Kentucky and are required to attain the CME credit.

KMA is in the process of developing a Legal Handbook, which will consolidate all Kentucky statutes relating to health care. The handbook will be made available to members as a member benefit. KMA has also developed a Web page on the Internet, www.kyma.org. The site will allow immediate access to information and rapid changes. We anticipate that the Web site will offer a new and more effective means of communication with the membership.

A report on the Legal Trust Fund is included annually in the Chair's Report. Expenditures were made during the past year of $1,436.50, and the Fund's balance as we prepared this report was $388,536.

The Ad Hoc Committee on Alternative and Unconventional Medicine, under the chairmanship of Dan W. Varga, MD, is charged with reviewing and evaluating information available on alternative unconventional therapies in order to be able to offer comment on the validity or lack of validity of various therapies. The committee met on two occasions this year. The first meeting dealt primarily with organizational procedures and future directions of the committee and topics for consideration at later meetings.

The committee will review, make recommendations, and disseminate information to patients and physicians; serve in an ad hoc advisory capacity to the Board of Medical Licensure on specific issues as they arise; help educate, serve as a resource, and inform physicians on alternative practice modalities, and disseminate information to patients. The committee hopes to present papers to the *Journal* of KMA for consideration, as well as the Public Education Committee's *MediScope*.

The Kentucky General Assembly adopted House Bill 160, which established a Committee on Alternative Therapy to study the issue and report back to the General Assembly in 2000. Bob M. DeWeese, MD, has been appointed Vice Chair of that committee which has several physicians including the Deans of the U of L and UK Medical Schools; Don Swikert, MD, from the Board of Licensure; and John White, MD, of Lexington representing KMA. The KMA Ad Hoc Committee plans to closely monitor the General Assembly study committee and review its efforts.

The committee adopted the following recommendations which were accepted by the KMA Board of Trustees at its August Board meeting: that the ad hoc committee become a permanent committee of KMA and the name be changed to the Committee on Complementary and Alternative Therapies.

The Committee will make extensive efforts in the coming year to seek some understanding of alternative and complementary health, and attempt to offer to members of the KMA information on the various topics related to the issue.

It has been a unique experience to serve as your Chair. I have learned much, and appreciated the opportunity. I have attempted to serve you to the best of my abilities.

The following summary of Board meetings is designed to give you a quick review of your Board's activities. Routine Board meetings last two days and complete Minutes of all Board meetings will be provided to Reference Committee A. The committee reports give you additional insight into your Association's involvement on your behalf.

Summary of Board Meetings

First Meeting, September 18,1997

The KMA Board of Trustees held its reorganizational meeting for the 1997-98 Association year on September 18, 1997. Acting Chair William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers. Donald R. Stephens, MD, Cynthiana, was named President-Elect, and Harry W. Carloss, MD, Paducah, was elected Vice President. Newly elected Trustees were Robert C. Hughes, MD, Murray, 1st District; John M. Patterson, MD, Frankfort, 7th District; and Andrew R. Pulito, MD, Lexington, 10th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1997-98 KMA year. J. Gregory Cooper, MD, Cynthiana, was elected Chair, Board of Trustees, and Donald R. Neel, MD, Owensboro, was reelected Vice Chair. Kenneth R. Hauswald, MD, Ashland, and Thomas E. Bunnell, MD, Crestview Hills, were named as Trustees-at-Large.

Five physicians were elected by the House of Delegates to serve on the 1998 Nominating Committee. Members elected were: Susan M. Berberich, MD, Louisville, Chair; Lucian Y. Moreman, MD, Elizabethtown; Mary Jo Ratliff, MD, Pikeville; Dennis B. Kelly, MD, Lexington; and John S. Cave, MD, Henderson.

Second Meeting, December 17-18,1997

The KMA Board of Trustees met on December 17-18, 1997, at the KMA Building in Louisville.

KMA President, C. Kenneth Peters, MD, presented his goals for 1998: a successful legislative session, two regional trustee district meetings, and a strategic planning seminar. The first regional trustee district meeting is scheduled for April 22, 1998, at the Riverpark Center, Owensboro. A strategic planning seminar is scheduled for May 27-28, 1998, in Shakertown.

Donald C. Barton, MD, Senior Delegate to the AMA, summarized the 1997 AMA Interim Meeting in Dallas. Ardis D. Hoven, MD, Lexington, has been nominated for a position on the AMA Council on Medical Service; and Bruce A. Scott, MD, Louisville, is running for the young physicians slot on the AMA Board of Trustees.

Additional reports were presented by William P. VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Chair, KEMPAC Board of Directors; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner for Health Services; Mrs. Aroona Dave, Alliance President; James B. Holloway, MD, Acting Medical Director, AdminiStar; and Danny M. Clark, MD, President, Kentucky Board of Medical Licensure.

A progress report on the Regional Partnerships was presented. Larry N. Cook, MD, Chair, Department of Pediatrics, University of Louisville School of Medicine, reported that start-up began in November in Region 3 with 43,000 enrollees, with another 18,000 expected in January. Over 500 primary care physicians and approximately 1,200 specialists have signed contracts. James R. Bean, MD, Lexington, reported that Region 5 is operating with 71,000 enrollees at present and another 25,000 are expected to enroll by April 1. Approximately 400 primary care physicians and 750 specialists have joined the partnership in Region 5. Richard T. Heine, PhD, Manager, Medicaid Waiver Project, reported on developments in the remaining regions.

Robert R. Goodin, MD, Immediate Past Chair, KMA Physicians Plan, Inc, reported that the KMAPP Board of Directors, at its meeting on October 30, 1997, recommended that efforts to develop a KMA-sponsored managed care product be discontinued as a result of a survey conducted by Ernst & Young, which indicated that financial and business barriers made such a venture unfeasible. The KMAPP Board recommended that KMAPP continue with new focus areas such as a managed care support service, leadership courses for physicians, and managed care seminars.

The Board adopted Agenda B to implement all actions of the 1997 House of Delegates.

Two new committees, the Ad Hoc Committee on Alternative and Unconventional Medicine and the Ad Hoc Committee to Recommend a Section on International Medical Graduates were appointed. Kenneth R. Hauswald, MD, Ashland; Eugene H. Shively, MD, Campbellsville; and Robert C. Hughes, MD, Murray, were appointed to the KMIC Board Nominating Committee.

Legal Counsel updated the Board on the federal health benefit plan for mail carriers and lawsuits challenging Kentucky's Any Willing Provider Law. The Any Willing Provider Law is not being enforced, pending a decision in the suit.

Reports were given by the Committees on National and State Legislative Activities, the Public Education Committee, Committee on Medicaid Managed Care, Ad Hoc Committee on Faculty Membership, Continuing Medical Education Committee and the Committee on Child and School Health. The first Fraud and Abuse Seminar, recommended by the Committee to Investigate Changing Trends in Medicine, is scheduled for February 5, 1998, at KMA Headquarters.

It was noted that the 1998 Annual Meeting will be held in Louisville September 20-24. The theme for the meeting is "The Team Approach to Healthcare: The Physician's Role."

The next meeting of the KMA Board of Trustees was scheduled for April 8-9, 1998, at the KMA Building.

Third Meeting, April 8-9,1998
The KMA Board of Trustees met in regular session on April 8-9, 1998, at the KMA Building in Louisville. Board members heard reports from the President; Secretary-Treasurer; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Senior Delegate to the AMA; Chair, Kentucky Medical Insurance Company Board of Directors; President, KMA Alliance; and the Commissioner, Department for Public Health.

The Board adopted the budget for fiscal year 1998-99. In further action, the Board approved the nominees for reelection to the KMIC Board of Directors; selected nominees to the Breast Cancer Advisory Committee and the Breast Cancer Task Force; and reappointed the KMA/KMIC Board Joint Advisory Committee.

The Board adopted the recommendation of the Committee on Insurance and Prepayment Plans to collect information from members on the shifting of administrative burdens and costs by insurance companies to physicians. The Board also approved a survey of International Medical Graduates in Kentucky to determine unmet needs. In further action, the Board authorized KMA to allow credit card payments for dues and other KMA resources.

Additional reports were given by the Committee on Medicaid Managed Care, the Committee on National Legislative Activities, the Committee on State Legislative Activities, the Public Education Committee, and the Committee on Child and School Health.

The Board also heard information on HCFA Evaluation and Management Guidelines, web page development status, Fraud and Abuse Seminars, and Regional Trustee District meetings.

It was noted that the theme for the 1998 Annual Meeting is "The Team Approach to Healthcare: The Physician's Role," and that Nancy Dickey, MD, AMA President Elect, has been invited to attend dinner with the Board on Sunday evening and to address the House of Delegates on Monday.

The KMA Board of Trustees will hold its next regular meeting on August 5-6, 1998, at the KMA Building.

Fourth Meeting, August 5-6, 1998
The KMA Board of Trustees met on August 5-6, 1998, at the KMA Headquarters Office in Louisville.

C. Kenneth Peters, MD, President, reported on the strategic planning meeting held in Shakertown last May and noted that all participants had received the report from the session.

The Board members heard routine reports from William P. VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Chair, KEMPAC Board of Directors; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner for Public Health; Mrs Jan Crase, Alliance President; and Preston P. Nunnelley, MD, Kentucky Board of Medical Licensure.

Donald C. Barton, MD, Senior Delegate to the AMA, reported that Bruce A. Scott, MD, was elected to the young physicians slot on the AMA Board of Trustees; Ardis D. Hoven, MD, won a seat on the Council on Medical Service; and William B. Monnig, MD, was reelected as Secretary of the Governing Council of the Organized Medical Staff Section.

The new Dean of the University of Louisville School of Medicine, Joel A. Kaplan, MD, was introduced to Board members. The Board voted to include a $10 voluntary assessment for the Legal Trust Fund with the 1999 dues billing.

Appointments were made to the KEMPAC Board of Directors and a Judicial Council nominee was approved. The Board approved nominees for the Kentucky Board of Medical Licensure, Drug Management Review Board, Kentucky EMS Council, Kentucky ACTION, and the AdminiStar Medicare Carrier Advisory Committee.

The Board heard additional reports from the Committees on State and National Legislative Activities, Committee on Medicaid Managed Care, Committee on Community and Rural Health, Ad Hoc Committee on Alternative and Unconventional Medicine, and the Public Education Committee.

An update was given on the Annual Meeting, and action was taken on 40 committee reports.

The next meeting of the Board was scheduled for Sunday, September 20, 1998, during the KMA Annual Meeting.

Executive Committee
The KMA Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the association and to research and make recommendations to the Board of Trustees on issues of major concern. The Executive Committee is composed of eight officers and trustees, and they met on five occasions this past year. They are truly dedicated physicians.

Quick Action Committee
Four officers comprise the Quick Action Committee, namely the President, President-Elect, Chair of the Board, and Secretary-Treasurer. In addition, during legislative sessions our group also includes the Chair and Vice Chair of our State Legislative Activities Committee.

Ad Hoc Committees
There were five ad hoc committees of the Board working on projects this year. Detailed reports of the KMA Membership Task Force, the Ad Hoc Committee on Faculty Membership, the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan, the Ad Hoc Committee on Complementary and Alternative Therapies, and the Ad Hoc Committee to Recommend a Section on International Medical Graduates appear elsewhere in this book.

Closing Comments
I appreciate the work done by all the committee chairs and members, members of the Board and officers, delegates, and every member of KMA. Serving as your chair has been a challenging and rewarding experience. Thank you for that privilege.

J. Gregory Cooper, MD
Chair

Report of the Secretary-Treasurer

It is my pleasure to report to you as Secretary-Treasurer of the Association and to report to you on some of the activities of your organization this year.

The theme of this year's Annual Meeting is "Team Approach to Health Care." As usual, a great deal of effort has gone into the production of the scientific part of the program, as well as the business portion. The Scientific Program Committee is to be congratulated for its usual outstanding efforts in planning and coordinating this part of the meeting. Also, congratulations are due to the represented medical specialty groups for their coordination and assistance.

Some special programs have been planned this year that are worthy of the attention of members attending the meeting. On Tuesday, September 22, a special session has been planned on Contracting Issues for Physicians. The speaker for this meeting will be a representative of the American Medical Association's Division of Physician and Patient Advocacy. Concerns relating to contracting will be addressed and, hopefully, some actual contracts from Kentucky organizations will be considered.

On Thursday, September 24, a seminar on Domestic Violence has been scheduled beginning at 9:00 AM. This seminar has been designated for three hours of mandatory continuing medical education required by the state of all primary care physicians.

In addition, a special meeting for young physicians has been scheduled for noon on September 22, and at 1:00 PM on the 22nd, the annual meeting of the Medical Student Section and Resident Physician Section will be held. During this week, the Alliance will also conduct its fall board meeting and other activities, which are listed in the schedule of events accompanying this packet.

The entire meeting is designated for 15 hours of Category 1 continuing medical education by the KMA, and is recognized also by the American Academy of Family Physicians.

The Board of Trustees addressed two unique issues this year through the appointment of ad hoc committees to deal with specific issues. Ad hoc committee reports dealing with medical school faculty membership and the question of the formation of a section for international medical graduates appear in these materials. Your attention is directed to these matters. These ad hoc groups are noted to give an indication of the efforts of the Board of Trustees to respond to emerging issues.

Three other matters developed through the year are worthy of particular note. First, was the creation and production of a strategic planning process by President Peters, which he will doubtless address, and will be acknowledged in other materials presented. A second effort was the conduct of regional meetings, again under the auspices of President Peters, to try to bring KMA to the membership with the highlight of urgent issues. The third matter of note was KMA's efforts related to patient protection legislation, both in the

Kentucky General Assembly and with Kentucky members of Congress. These items are mentioned to reflect continuing focus by the Board of Trustees on the advocacy of the profession, both externally and internally, to respond to the changing needs of medicine.

The business affairs of the Association are in good order. Please take time to consider the budget information that is provided. Through careful stewardship, your Board of Trustees has maintained the conservative fiscal operation of KMA, and the leadership will be present to address any questions on these matters during reference committee meetings.

Each year I am privileged to take part in many activities within KMA, and so have routine and often intense association with the leadership. I have been honored to work this year with President Ken Peters, President-Elect Don Stephens, and Board Chairman Greg Cooper whose dedication to KMA and our profession is truly noteworthy. It has also been gratifying and fulfilling to work with the Board of Trustees and the outstanding representation they bring of all members across the state.

I have been equally privileged to work with Bill Applegate, our chief executive officer, and the other members of the staff whose devotion to the Association certainly exceeds the routine demands of an avocation. Finally, I would like to express my thanks to this House of Delegates for the honor you have shown me by electing me to this position and for your confidence.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The *Journal of the Kentucky Medical Association* has been devoted to the interests of the medical profession and public health in Kentucky since 1903. It remains the foremost publication about practicing medicine in Kentucky, and its success lies in the hands of the membership. *The Journal* stands tall among the medical journals of other state associations, and the Editorial Board sincerely hopes it meets your needs and helps to make you proud to be a member.

The editors dedicate many hours to improving the educational and scientific value of *The Journal*. They attempt to keep abreast of the most current and innovative medical studies and reports. This group constitutes a broad specialty representation—Daniel W. Varga, MD, Scientific Editor, internal medicine; Stephen Z. Smith, MD, Assistant Scientific Editor, dermatology; and Assistant Editors Kimberly A. Alumbaugh, MD, obstetrics/gynecology; Carolyn D. Burns, MD, pathology; Daniel P. Garcia, MD, allergy and clinical immunology; Jaroslav P. Stulc, MD, general surgery; and your Editors' area of expertise is gastroenterology/internal medicine.

In December 1997, Assistant Editor Milton F. Miller, MD, announced his retirement from the active practice of medicine, and, alas, his resignation from the Editorial Board. Milton was a strong, active, and contributing member of the Board for more than 20 years, and we have benefited from both his counsel and wisdom. He brought *The Journal* perceptivity as he described the maelstrom of medicine through his fine editorials, many of which were reprinted in other publications. He will be missed.

Dr Dan Garcia was appointed to fill this vacancy and has stepped in with enthusiasm and vigor. He is doing an excellent job.

The Board met 9 times during 1997, and of the 36 manuscripts reviewed (all unsolicited), the editors rejected 4 and returned 7 with recommendations for revision, indicating a 69.5% acceptance rate.

During 1997, *The Journal* featured 17 original scientific articles representing the efforts of 53 authors; 5 Grand Rounds contributions representing 6 authors; and 13 special articles representing 26 authors. The special articles presented a rich variety of socioeconomic information on advancing technology, legal issues, ethics, and academic trends. *The Journal* also featured a complete preliminary program for the 1997 Annual Meeting, as well as the entire proceedings of that meeting; several discerning contributions by Book Review Author Stephen Z. Smith, MD; Alliance updates; numerous editorials and letters discussing medical issues of interest to Kentucky physicians; a plethora of pertinent information in the highly successful monthly section headlined "Monitoring Medicine"; and of course, Association coverage.

Maintaining the economic health of *The Journal*, while at the same time maintaining a high standard of scientific quality, remains a priority. Costs continue to be significantly controlled, and *The Journal* Board and staff remain vigilant in their efforts to provide the best publication possible within our budget constraints.

As we ponder the challenges certain to be encountered in the coming year, we recognize that the need for active physician participation in all areas of Association affairs has never been greater. The Board hopes that you, our readers, will use *The Journal* as a vehicle for expression and communication. We might all benefit from grass-roots ideas, opinions, and perhaps an occasional view of the trees instead of the forest. We welcome your correspondence.

The Editorial Board thanks the Board of Trustees and all members of the Kentucky Medical Association for your continued support.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

Your AMA delegation represented you diligently and faithfully at the two meetings held for the House of Delegates this year. At each of these two meetings reference committees meet for two full days, and the House of Delegates meets for two or three full-day sessions. At each of these meetings, over 70 reports by the Board of Trustees and the AMA councils are considered, as are over 150 resolutions submitted by constituent societies. Each delegate and alternate delegate has a routine reference committee assignment, and materials are assigned to reference committee by topic. As a result, each member of the delegation becomes expert in the areas of his/her reference committee topics.

To best represent you in reference committee testimony and from the House floor, each delegate and alternate must study and become familiar with each new issue. Likewise, Kentucky's concerns are represented in reference committees and before the House by way of resolutions. In the past year and a half, the AMA House has adopted three resolutions submitted by Kentucky on your behalf.

It is important that you know who the people are who represent you, and have some appreciation for their service. Your elected Delegates are: Wally O. Montgomery, MD, Paducah; Robert R. Goodin, MD, Louisville; Ardis D. Hoven, MD, Lexington; Donald J. Swikert, MD, Florence; and myself. Alternate Delegates are: Bob M. DeWeese, MD, Louisville; J. Gregory Cooper, MD, Cynthiana; Preston P. Nunnelley, MD, Lexington; William B. Monnig, MD, Edgewood; and Baretta R. Casey, MD, Pikeville.

Other physicians from Kentucky also attend AMA meetings representing you from other constituencies. John D. O'Brien, MD, Louisville, Chair of the KMA Organized Medical Staff Section, routinely attends House meetings, as do other KMA-OMSS representatives. Representatives of the Medical Student Section at both schools attend, as do representatives of KMA's Resident Physician Section and KMA's Young Physicians Section. In addition, F. Douglas Scutchfield, MD, Lexington, is the Delegate from the American Public Health Association, and Judy M. Linger, MD, Georgetown, is the Alternate Delegate from the American Psychiatric Association. Both of these individuals represent KMA's concerns, as well as those of their specific groups.

KMA's major concerns at the AMA meetings this year related to elections. As you are probably aware, Bruce A. Scott, MD, Louisville, who served as the Delegate from the AMA Young Physician Section, was elected to the young physician slot on the AMA Board of Trustees for a term of four years. Ardis D. Hoven, MD, Lexington, was elected to a three-year term on the Council on Medical Service in a highly contested race. As you may appreciate, competition for these positions is intense for the simple fact that all candidates are very well qualified. Obviously, we feel the Kentucky candidates are the most qualified, and the House agreed with this assessment by electing both of Kentucky's campaigners.

Extraordinary efforts were made by Dr Scott and Dr Hoven, who were strongly assisted by all members of the Kentucky delegation, who also gave a great deal of effort, and are to be congratulated. Another successful race was run by William B. Monnig, MD, Edgewood, for Secretary of the Governing Council of the AMA Organized Medical Staff Section. Dr Monnig was reelected to his second term in this position.

In spite of its relatively small size, Kentucky has obtained a notable share of AMA positions, including that held by Robert R. Goodin, MD, who is serving as an elected member of the Council on Medical Education.

Earlier mention was made of three resolutions carried by Kentucky to the AMA House. The first, which dealt with the Pap smear screen as a clinical laboratory test, sought a change in Medicare payment policy to reimburse for

Pap smear screens as medical consultations rather than clinical laboratory services. The House of Delegates directed the AMA to use legislative and regulatory means to change this policy so that reimbursement for the technical component of the Pap smear service is adequate to cover the cost of providing the service, and pathologists are reimbursed for interpretation of abnormal Pap smears based on the RBRVS.

The second Kentucky resolution adopted by the AMA dealt with enforcing the AMA Current Procedural Terminology licensing agreement. This resolution protested the practice by carriers of bundling CPT codes and revising them to reduce payments to physicians. This effort is ongoing.

A third issue that Kentucky generated was the establishment of the liability of managed care organizations and individual managed care employees. This resolution sought changes in federal law to prohibit the exemption from liability of managed care organizations for damages resulting from their policies and procedures. As is now well known, this is a major legislative priority of the AMA and is incorporated in the patient protection package now being vigorously pursued in Congress.

This report details only the briefest highlights of the activities of your AMA delegation. Following each meeting of the AMA House of Delegates a report is published in the *Journal* of a summary of actions, for your information. As Chairman, I would encourage all delegates to contact one of the AMA delegates or alternates for further discussion on any issues. Also as Chairman, I would like to humbly thank the other members of the delegation for their excellent efforts, and I would like to thank the members of this House for electing each of us and allowing us to serve.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

"I live in the future, never in the past." Those were the words of President Ken Peters, MD, when I remarked on his ability to view challenges and problems in a positive light. Dr Peters put that philosophy into action this year by convening KMA's first strategic planning exercise. Well conceived, planned, and executed, the results of the Shakertown meeting will serve the members of the Association well into the future. Thirty members representing different specialties, genders, nationalities, ages, and viewpoints came together in a setting free of distraction for 36 hours to brainstorm the future of medicine in Kentucky. Some were officers of the Association with many years of experience, some were long-term members serving on key KMA committees, while others were just beginning their careers and had a significant interest in what the future holds for them. A representative of the Alliance and senior staff members also participated.

Membership's perception of KMA was generated by a survey of the members of the KMA House of Delegates, young physicians, female physicians and international medical graduates. While we were hopeful a 50% response would be possible, we were proud that we actually achieved a 61% response. Our consultants tell us the survey results have a high degree of accuracy. In addition, individual interviews were conducted with nonphysician community leaders to obtain another perspective on health care in Kentucky and KMA. These individuals gave freely of their time and their opinions, which added a useful dimension to our information base. A summary of the plan is being made available to the House and we are hopeful members will review it when they have the opportunity.

It has truly been a growing experience to work with Dr Peters this year. He is a person who sees the need for medicine to embrace the future by becoming comfortable with change and by encouraging the participation and involvement of all physicians. He represented KMA well in public forums and always articulated the Association's message to physicians, allied health groups, and government officials, including Governor Patton and President Clinton. He followed the will and direction of the membership in forming decisions in accordance with House of Delegates action. His presidency marks the pinnacle of a long and distinguished career in Kentucky medicine, and his efforts this year will, I believe, leave a legacy for those that follow him for years to come.

Greg Cooper, MD, has impressed us all with his ability to digest information, to bring the Board of Trustees to consensus, and to articulate the desire of the Board on many different and sometimes controversial issues.

Don Stephens, MD, has been a mainstay at KMA for years, serving as President of the Rural Kentucky Medical Scholarship Fund and as a past Chair of the Board, among other things. He has a way of quickly getting to the point with a common sense approach to issues. We look forward to working with him next year during his term as President.

Dr VonderHaar continues to awe us with his commitment to the role of Secretary-Treasurer. That office carries with it the job of being counselor, chief medical doctor, sounding board, mentor, and friend to the staff. We are very grateful for his availability, and we thank him for his devotion.

This year was a legislative year which once again found State Legislative Chair Wally Montgomery, MD, making the long round trip drive from Paducah to Frankfort every Wednesday in unpredictable winter weather. He is always available to anyone wishing to discuss KMA legislative policies. He does an incredible job for the Association, and KMA is fortunate to have him in this most important role.

KMA Past President and member of the Kentucky House of Representatives Bob DeWeese, MD, played a vital role in the passage of patient protection legislation this year. His political savvy and knowledge of the health care system has made him a highly respected and influential member of the legislature. KMA is fortunate to have one of its own in a key position during a time of unprecedented change in Frankfort.

The Kentucky delegation to the AMA is small in comparison to some other states, which is sometimes a barrier for members of the delegation willing to serve in a national capacity. A highlight of the past year was the election of three KMA members to AMA offices. Past President Ardis Hoven, MD, was elected to the AMA Council on Medical Service in a run off after a dead heat tie eliminated three other candidates. Bruce Scott, MD, was elected to the young physician slot on the AMA Board of Trustees. To be elected to the AMA Board at an early age is a significant recognition. William Monnig, MD, was reelected as Secretary of the Organized Medical Staff Section, an organization of representatives of medical staffs from across the country. Those victories, coupled with the current service of Robert Goodin, MD, on the AMA Council on Medical Education, gives Kentucky a national presence unequalled by any other small state delegation. Outstanding candidates and the political expertise of Delegation Chair Don Barton, MD, was an unbeatable combination.

KMA welcomed two new medical school deans this year. Joel Kaplan, MD, succeeded KMA's long-time friend, Don Kmetz, MD, who retired from the University of Louisville School of Medicine after many years of service. We appreciate the support and participation of Dr Kmetz over the years and look forward to working with Dr Kaplan in his new role. John Strosnider, DO, serves as Dean of the School of Osteopathic Medicine in Pikeville. We look forward to developing a strong relationship with the faculty and students.

Membership in KMA remains strong, although active membership is down slightly from last year when the majority of the faculty of the University of Kentucky joined KMA. KMA's membership among those eligible for active membership is 74%. That means that about one out of four of your colleagues are benefiting from KMA's legislative, legal, educational, and advocacy representation without bearing their fair share of the financial responsibility. All physicians have the obligation to be a part of organized medicine. There is not one facet of medicine untouched by KMA and the AMA. Organized medicine needs physician time and money. If people are unable or unwilling to give time, they should at least be willing to financially support the only organizations that represent the interests of the entire profession and their patients. A member-get-a-member campaign will be launched at the Annual Meeting. Experience has shown that peer-to-peer contact is the most successful form of recruitment and peer involvement is the most successful form of retention. The goal is to reach an active member rate of 80% of those eligible. If every member of the House could bring one new member into KMA, the Association would be well on its way to that benchmark.

Managed care continues to be a major concern for medicine. Enactment of the Patient Protection Act in Kentucky was one step in the right direction. Enactment of the bipartisan bill introduced into Congress that would hold ERISA-exempt health plans responsible for harm to patients when plans refuse to pay for treatment would be another. Unfortunately, many of the members of Congress supported by medicine in the past have chosen to vote for a watered down, poorly conceived, and useless bill that does little to protect the rights of patients and would actually preempt sound legislation already passed in many states. Patient protection has become the major health issue of the year and may well become the major national political issue this November. It has become THE priority of the AMA's political agenda. Medi-

cine will prevail on this issue because it is the right thing to do for the right reasons.

The Evaluation and Management Codes proposed by HCFA, combined with an emphasis on the vigorous implementation of existing laws on Medicare fraud and abuse, met with quick and spirited action from the AMA. HCFA will not require the use of the new guidelines pending further negotiations with AMA and other medical organizations. KMA held several Fraud and Abuse Seminars around the state attended by over 600 members. Others are planned for this fall. The AMA will present a contract review seminar at the 1998 Annual Meeting to provide members with information to better evaluate and negotiate contracts with third-party payers.

Kentucky's activity to move Medicaid recipients into managed care is being carefully monitored by KMA. A report on the status of the various approaches to serving the Medicaid population is included in the committee reports presented to the House.

The pendulum may have begun to swing the other way on managed care. Columbia/HCA, once seen as a managed care success story, apparently built its incredible growth on highly questionable if not illegal practices. The Chair and CEO of United HealthCare, speaking in Louisville, said that the merger of Humana and United would give the company the people, money, and information to change the future of health care, only to report a few weeks later that the company had sustained massive losses which led to the termination of merger talks. Oxford Health Plans, along with many other managed care plans, have also reported huge losses this year. Patients are frustrated with rising premiums, having costs shifted to them personally, and decreasing coverage. They are fed up with premiums that pay for expensive advertising, stockholder dividends, and high executive salaries while the companies deny payment for services the patients and their physicians feel are necessary. The importance of national patient protection in upcoming congressional elections is one indication of the anger and frustration over managed care. The growth of point of service options is another, the result of the desire of patients to be able to choose their physician.

This report does little more than scratch the surface of the level of activity of KMA officers, volunteer committee members, the Alliance, and staff. These individuals give significant time and energy to try to do what's best for the public, the profession, the patient, and the individual physician. Their dedication, energy, integrity, and level of commitment are exemplary.

I cannot begin to adequately convey my appreciation for members of your staff that work on your behalf seven days a week, fifty-two weeks a year. They understand their challenge and meet it head on. They understand their work and do it well. I want to use this report to thank and compliment each of them.

The Association remains in a financially strong position. Careful planning by the Budget Committee and continued oversight of our financial operation has provided us the ability to stretch our dues dollars. The last dues increase was anticipated to carry the Association for five years, but has gone well beyond that goal, and no increase in dues appears necessary in the near future.

On behalf of the entire staff, we thank all KMA members for their assistance and participation during the past year.

William T. Applegate
Executive Vice President

Report on the KMA Physician's Plan, Inc.

This is a report regarding the activities of the KMA Physician's Plan Incorporated (KMAPP). KMAPP is a wholly owned, for-profit subsidiary of the Kentucky Medical Association. This report is made for information purposes only.

In 1996, the KMA House of Delegates passed a resolution which called for the formation of a managed care organization run by KMA. KMAPP representatives discussed with several entities and consultants the possibility of forming such an organization. After several meetings, the KMAPP Board decided to conduct a survey of the Kentucky health care market to determine what, if any, type of health plan would be feasible to establish.

To conduct the market survey, KMAPP hired Ernst & Young of Louisville, who conducted interviews with physicians throughout the state, as well as a number of payers, employers, and representatives of other managed care entities to determine what level of interest there may be in a KMA-sponsored network. Ernst & Young also reviewed various market and financial data obtained from a number of sources and presented all of this material to the KMAPP Board of Directors.

KMAPP established certain goals and objectives that would have to be met before proceeding with development of a network. Those goals and objectives were:

- Maintain physician dominated governance.
- 100% physician control of clinical decisions.
- Be a dominant player in the market.
- Cover development costs in two (2) years.
- Break even in three (3) years.
- Provide a return on investment in five (5) years.
- Provide another option for KMA physicians practicing in rural markets.
- Obtain commitment from 2,000-2,500 KMA members.
- Use KMAPP as a vehicle to maintain or grow KMA membership.

KMAPP also established three deal breakers that would make the establishment of a network nonviable. These deal breakers were:

1. Insufficient market demand for a KMA-sponsored network.
2. The establishment of the network would be financially nonviable for KMA.
3. A lack of support by the KMA membership.

As part of the market survey, the KMA membership was surveyed to determine the level of interest in forming a statewide network. The results of that survey revealed that just under 10% of KMA membership would be willing to help KMAPP establish the network by dealing with employers and hospitals, while just over 8% of KMA membership would be willing to contribute up to $500 toward development.

The survey also explored various markets that might be feasible for KMAPP to penetrate. The first market to be surveyed was the commercial market. After reviewing the various types of commercial plans and how the population fit into each of them, KMAPP concluded that 89% of the commercial market was already taken.

With the market heavily saturated by other managed care organizations, KMAPP could find little interest from employers around the state for a KMA-run network. They also found limited statewide opportunities for such a network, mainly because there are not many companies who have a statewide presence. There was also no interest expressed by the larger payers around the state. Some minor payers did express interest, but there was a minimal number of covered lives they could offer to the network.

In order to establish an HMO, KMAPP would have to spend nearly $7.3 million just in the first year, with an additional $9 million spent over the next four years. The most important financial factor considered, however, was that there would be no break-even point in five years and accumulated losses to KMAPP would exceed $23 million. To establish a PPO, as opposed to an HMO, it was discovered that accumulated losses over five years would be more than $16 million. KMAPP also looked at the potential to become involved in the Medicaid market; but, with low premiums and the requirement that an organization must participate in a partnership to serve the Medicaid population, the Medicaid market did not seem feasible.

KMAPP found that the Medicare managed care market was just opening up in Kentucky. In order to compete in the Medicare managed care market, KMAPP would have to launch a two-county pilot project to determine if a statewide Medicare managed care network would be feasible. For such a pilot project, the survey concluded that there would be no break-even point in four years and losses of more than $13 million would be accumulated in that time period. Again, this is just for a two-county pilot project; it does not represent the amount of losses that would be incurred in a statewide Medicare managed care product.

After examining the entire Kentucky market, KMAPP reviewed the deal breakers that had been set at the beginning and reached the following conclusions:

1. There is insufficient market demand for a KMA-sponsored network.
2. The establishment of the network would be financially nonviable for KMA.
3. There was a lack of support by the KMA membership for the formation of a network.

After receiving this report, the KMAPP Board of Directors voted not to establish a statewide network.

KMA is exploring various options as to what KMAPP might do in the future since a network will not be established. The strategic planning session conducted by KMA raised several possibilities, including the reconstitution of KMAPP as a committee to deal with managed care or business issues;

development of a forum to bring together the various IPA networks around the state and conduct educational sessions for them; and, having such a committee formulate educational sessions for KMA membership on business and managed care issues. These ideas are currently under consideration.

James R. Bean, MD
Chair

Report of the Kentucky Medical Insurance Company

Financial Highlights
(For the six months ending June 30, 1998)

- Professional liability premiums written were $22.4 million for the first six months of 1998, compared to $15.5 million for the same period in 1997. This represents a 44% growth in premiums.
- Workers' compensation premiums have grown phenomenally. Premiums written were $1.3 million for the first six months of 1998, compared to $307,000 for the same period in 1997, a 306% increase.

Marketing
- The number of physician policyholders is at an all-time record high. There were 3,869 physician policyholders as of June 30, 1998, a 56% increase over the June 30, 1997 count of 2,485.
- Opportunities within the Ohio market continue to grow. That region now accounts for 38% of KMIC's professional liability premiums written.
- The renewal retention rate is approximately 90% through June 30, 1998.

Claims	*As of June 30*	
	1997	1998
Claims opened	211	254
Claims Closed without indemnity	101	127
Claims Closed with indemnity payments	20	34
Net Indemnity Payments	$1,356,761	$5,834,886
	Tried	*Won*
1998 trial record as of 6/30/98:	29	23

Risk Management
- KMIC's fall risk management programs begin on August 5 and run through October 28, 1998. The seminars are customized and targeted to Kentucky and Ohio physicians, physician assistants, nurse practitioners, and clinical staff. Planned for the remainder of this year are 37 seminars.

General Management
- Effective July 8, 1998, Michigan Physicians Mutual Liability Company changed its name to Mutual Insurance Company of America (MICOA). This name change reflects the company's commitment to its customers across America, as well as its growth and diversification.
- KMIC participated in the 1998 Metro United Way Campaign with huge success. An overwhelming number, or 98%, of the employees funded this year's effort. With employee pledges of $7,115 and with employee fund-raisers generating a total of $1,008.80, a grand total of 48,123.80 was achieved.

Richard F. Hench, MD
Chair

Report of the Ephraim McDowell Cambus-Kenneth Foundation

The Ephraim McDowell Cambus-Kenneth Foundation was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively for "charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance." The Foundation was formed by the KMA for the purpose of accepting from Joe A. Wallace and Cecil Dulin Wallace, upon their deaths, the 550-acre Cambus-Kenneth Farm located in Danville, Kentucky. For many reasons, including the cost of maintaining the grounds, the farm was not turned over to the Foundation when Mrs Wallace passed away last year.

The Foundation continues to function, however, as the property holder of the McDowell House and other assets. The Board of Directors of the Foundation met during the year to discuss changing its membership. Since the Foundation Board of Directors has met for the past few years only to elect new officers, it was decided that the Board should constitute members of the McDowell House Managers Committee, which meets regularly and makes most of the decisions for the management of the McDowell House. The Foundation's by-laws were changed to reflect the new membership of the Board and new officers were elected.

Since the Foundation is a separate not-for-profit corporation, this report is provided to KMA for informational purposes only.

G. Russell Shearer, MD
President

END OF CONSENT CALENDAR ITEMS

Report of the Physician Advisory Committee to Health Kentucky (Health Care Access Foundation)

The Physician Advisory Committee to Health Kentucky has overall responsibility for monitoring and guiding the referral system to the Health Care Access Foundation Program. Members of the operational committee also serve as a medical advisory group on questions that may arise during the course of the program's operations.

The Kentucky Physicians Care Program, which is the physician element of Health Kentucky, provides access to nonemergency health care to uninsured Kentuckians with incomes at or below 100% of the federal poverty level at no cost to the patient.

Originally, the Kentucky Physicians Care Program offered only physician and hospital services. Now, at no cost, pharmaceutical products, dental care, hospice, and home health care services are also available. This year over 2,000 Kentucky physicians are participating in the program.

In addition to physician participation, there are 100 participating hospitals, 160 participating dentists, and 458 participating pharmacists. An unknown quantity of free home health care and hospice services have also been provided through this program. The biggest increase in utilization has come in pharmaceutical services as additional companies and products are being added.

In an effort to expand physician participation, targeted letters were sent to physicians in several KMA trustee districts and the committee appreciates the effort given to increase participation levels. Health Kentucky, Inc, was nationally recognized in February 1998 as the recipient of the sixth annual Monroe and Trout Premier Care Award. The award recognized an exemplary effort to make healthcare accessible to the medically underserved.

As in the past, the committee continues to believe that the program is worthwhile and serves a useful purpose providing a conduit for individuals to primary physician services. For that reason, the committee recommends:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
   a) Program funding being continued, as appropriate, by Health Kentucky.
   b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
   c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
   d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
   e) Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

I appreciate the continued interest and participation of the members of

the Advisory Committee and am most grateful for the generosity of the physicians in this state who continue to give so freely of their services.

Donald C. Barton, MD
Chair

RECOMMENDATIONS:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
   a) Program funding being continued, as appropriate, by Health Kentucky.
   b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
   c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
   d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
   e) Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

RECOMMENDATIONS, REFERENCE COMMITTEE A:
Reference Committee A reviewed Report 13 and its Recommendations pertaining to participants in Kentucky Physicians Care. Reference Committee A recommends the report and its Recommendations be adopted.

RESOLUTION 98-105

KMA Annual Meeting Dates
Jefferson County Medical Society

WHEREAS, the KMA has knowingly scheduled the KMA Annual Meeting on the Jewish High Holy Days this year; and

WHEREAS, a significant number of KMA members are Jewish; and

WHEREAS, the KMA has scheduled the Annual Meeting on the Jewish High Holy Days in the past and promised not to do so again; now, therefore, be it

RESOLVED, that the Kentucky Medical Association NOT schedule future KMA Annual Meetings on the Jewish High Holy Days.

RECOMMENDATIONS, REFERENCE COMMITTEE A:
Reference Committee A heard no discussion against this Resolution. Reference Committee A recommends that Resolution 105 be adopted.

RESOLUTION 98-112

Health System Reform
Fayette County Medical Society

WHEREAS, comprehensive health care reform failed in 1994, yet continues to evolve slowly through the legislature, insurance industry, executive branch of government, medical community, and court system without clear direction; and

WHEREAS, the Board of Trustees, the Quick Action Committee, the Legislative Committee, individuals and lobbyists of the Kentucky Medical Association should be overwhelmingly commended for their tireless and effective efforts to monitor and react to activities of the legislature, insurance industry, executive branch of government, medical community, and court system in the best interest of Kentucky physicians and their patients; and

WHEREAS, the American Medical Association has clearly articulated policies related to health system reform (AMA House of Delegates Handbook, Council on Medical Services Report 9, A-98, June 14-18, 1998); and

WHEREAS, everyone benefits for future planning from a more clearly articulated vision of an ideal health care system for an open, free-market democratic society; now, therefore, be it

RESOLVED, that the Kentucky Medical Association shall direct the Board of Trustees to produce an updated policy/guidelines statement in 1999 on Health System Reform. The policy/guidelines statement shall address the following issues:

1. universal coverage/access to include reasonable basic benefits, patient education, and significant patient responsibility for their own health care choices and behavior;
2. managed care fee-for-service option, and other payment options including balance billing;
3. physician and patient reasonable choice of plans and physicians;
4. regulatory hassles;
5. preservation of quality care;
6. antitrust relief;
7. tort reform;
8. insurance market reform on a local and national level:
   a. portability, availability, and renewability of coverage,
   b. access to private sector coverage for all persons, including the self-employed and economically disadvantaged,
   c. unfair pre-existing condition restrictions,
   d. simplified health benefit programs with full and clear information to allow consumers and providers to make easier participation decisions,
   e. consumption of benefits,
   f. contribution by employers towards the purchase of health benefit packages for their employees,
   g. catastrophic health insurance accompanied by individual tax deductible medical savings accounts or other health financing mechanisms,
   h. coverage of high-risk patients,
   i. reduction of administrative costs and profits that could be utilized for funding health care,
   j. patient protection provisions of HB 315 (DeWeese-Damron Bill);
9. the physician's responsibility and authority in medical decision-making and treatment in conjunction with the patient and the patient/physician relationship at the forefront with limited or no third-party interference;
10. inequities in the tax subsidization of insurance spending;
11. reward healthy lifestyles;
12. a balance of economic competition as the force for producing efficiency and innovation;
13. government regulation;
14. providers incentives to not over- or under-utilize;
15. fairness in regards to demographics and/or geographics;
16. recognize voluntary care given by physicians and hospitals to the poor;
17. health care providers diverted from their primary tasks of patient care by unnecessary clerical and documentation requirements;
18. single payor system of insurance coverage or nationalized health care;
19. information systems to judge quality and cost-effectiveness;
20. mechanisms in all methods of medical care payment to foster increased cost awareness by both providers and recipients of service.

RECOMMENDATIONS, REFERENCE COMMITTEE A:
Reference Committee A next reviewed Resolution 112, Health System Reform, submitted by the Fayette County Medical Society, supporting the creation of a policy or guideline statement by the KMA on items pertaining to health system reform. Testimony was heard regarding combination or addition of items listed.

The Reference Committee recommends that the Resolved be amended to read:

RESOLVED, that the Kentucky Medical Association shall direct the Board of Trustees to produce an updated policy/guidelines statement in 1999 on Health System Reform. The Board shall consider but not be limited to the following issues in the policy/guidelines statement.

Reference Committee A recommends that Resolution 112 be adopted as amended.

RESOLUTION 98-116

KMA Strategic Plan
Board of Trustees

WHEREAS, KMA completed its first strategic planning exercise this year due to the leadership and foresight of KMA President C. Kenneth Peters, MD; and

WHEREAS, the participants in the planning process generated the following major goals for the Association, which when implemented will serve the Association well into the future:

1. Maximize physician participation in organized medicine by enhancing services and facilitating better communications to members and targeting nonmembers for outreach. Work toward a 90% participation rate within five years.
2. Ensure an effective, year-round governmental program and seek a balanced partnership with government.
3. Preserve the doctor/patient relationship and emphasize the goal of "putting the patient first" as central to the integrity of medicine.
4. Position KMA to be a more active leader and advocate in influencing the managed care environment and to serve as a clearinghouse of information for practicing physicians.
5. Take a proactive role in defining and responding to the educational and ethical challenges arising from the new frontiers of medical knowledge.
6. Continue efforts to achieve tort reform and serve as a resource for medical-legal issues.
7. Establish new connections and strengthen existing physician ties with the broader health care community and the public at large.
8. Assume a leadership role in raising community awareness of health lifestyles, establishing health promotion and disease prevention as the "battle cry" of Kentucky medicine and taking the lead in establishing a better understanding of the role of "complementary" medicine.
9. Foster outcomes-driven quality of care across the state in the next five years.
10. Achieve universal access to health care for Kentuckians within five years.

Now, therefore, be it

RESOLVED, that the House of Delegates endorse the goals as developed through the Strategic Plan and support the Board of Trustees as it works to implement the KMA Strategic Plan.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 116, KMA Strategic Plan, submitted by the Board of Trustees, on the process of development and the organizational goals included in the 1998 KMA Strategic Plan entitled "KMA Future Search." The Committee heard favorable testimony regarding the process and goals listed.

Reference Committee A recommends the Resolved be amended to read:

RESOLVED, that the House of Delegates endorse the goals as developed through the Strategic Plan and support the Board of Trustees as it works to implement, periodically review, and report the progress of the KMA Strategic Plan.

Reference Committee A recommends adoption of Resolution 116 as amended.

RESOLUTION 98-121

Observer Status for Kentucky Academy of Physician Assistants
Board of Trustees

WHEREAS, the KMA Membership Task Force has recommended that the Kentucky Academy of Physician Assistants be given official observer status in the House of Delegates; and

WHEREAS, the Kentucky Academy of Physician Assistants has requested official observer status in the House of Delegates; and

WHEREAS, the Board of Trustees has reviewed this request on the advice of the Executive Committee and the Membership Task Force and finds it to be an appropriate activity; now, therefore, be it

RESOLVED, that the Kentucky Academy of Physician Assistants be granted official observer status at all regular and special meetings of the House of Delegates through one designated representative; and be it further

RESOLVED, that such observer receive all mailings, publications, and materials received by all regular delegates and be required to register for each meeting and wear an appropriate badge, but may not take part in House proceedings; and be it further

RESOLVED, that this specific appointment and process of conduct be adopted as a standing procedure of this House of Delegates.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 121, Observer Status for Kentucky Academy of Physician Assistants, submitted by the Board of Trustees. Testimony generally supported inclusion of a KAPA observer at House of Delegates proceedings in order to promote communication and understanding between physicians and physician assistants.

Reference Committee A recommends adoption of Resolution 121 as written.

Mr Speaker, Reference Committee A recommends the adoption of this report as a whole.

Mr Speaker, I want to personally thank the other members of Reference Committee A who attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the committee were: Beverly M. Gaines, MD, Louisville; Theodore H. Miller, MD, Edgewood; Charles G. Nichols, MD, Pikeville; Samuel R. Scheen, III, MD, Louisville; and Kate B. Wilson, Louisville. I also wish to thank Ms Carol Collett for her help and guidance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE A
James R. Bean, MD, Lexington, Chair
Beverly M. Gaines, MD, Louisville
Theodore H. Miller, MD, Edgewood
Charles G. Nichols, MD, Pikeville
Samuel R. Scheen, III, MD, Louisville
Kate B. Wilson, Louisville (MSS)

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE B

W. Lisle Dalton, MD, Lexington, Chair

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Continuing Medical Education Committee
17. Report of the Council for Continuing Medical Education
18. Report of the Cancer Committee
19. Report of the Physician Workforce Committee
20. Report of the Organized Medical Staff Section
21. Report of the Rural Kentucky Medical Scholarship Fund
    Resolution 106 — Credentialing of Nuclear Medicine Technologists (Jefferson County Medical Society)
    Resolution 107 — Guidelines for Pap Smear Review in Litigation: KMA Endorsement of College of American Pathologists Guidelines (Fayette County Medical Society)
    Resolution 109 — Physician Assistants (McCracken County Medical Society)
    Resolution 115 — Physician Education on End-of-Life Care (Board of Trustees)
    Resolution 124 — Physician Assistants (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee B reviewed the following items and recommends they be filed, by consent of the House, without discussion:

14. Report of the Scientific Program Committee — filed
15. Report of the Scientific Exhibits Committee — filed
16. Report of the Continuing Medical Education Committee — filed
17. Report of the Council for Continuing Medical Education — filed
18. Report of the Cancer Committee — filed
19. Report of the Physician Workforce Committee — filed
20. Report of the Organized Medical Staff Section — filed
21. Report of the Rural Kentucky Medical Scholarship Fund — filed

Mr. Speaker, Reference Committee B recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

"The Team Approach to Healthcare: The Physician's Role" was selected by the Scientific Program Committee as the overall theme for the 1998 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The committee members and representatives of the planning committee from the 21 specialty societies have worked hard to bring some of the nation's top speakers to the meeting, and it is hoped that the membership will find their presentations practical and helpful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 21 specialty groups that will participate in the annual session. The Scientific Program Committee discussed financial arrangements between KMA and the specialty groups and recommended that the honorarium for out-of-state guest speakers be increased from $300 to $400, as well as up to, but not exceeding, $650 in expenses. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven to be very popular, and provide an excellent source for the continuing medical education of the membership. I personally appreciate the excellent cooperation the committee has had from all of the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance, and encourage them to continue to assist the committee in finding new and innovative ideas for topic selection and presentation.

The 1997 Annual Meeting was held at the Hyatt Regency Hotel/ Commonwealth Convention Center in Louisville, Kentucky, with an attendance of 2,380.

Exhibitors were asked to fill out evaluation forms on Tuesday and Wednesday during the 1997 meeting. This allowed a better assessment of exhibitors' viewpoints and new ideas which they may have for improving the meeting to be considered by the Scientific Program Committee. The exhibitors' comments were, overall, positive.

Results from physicians' evaluation forms from the general sessions and specialty group meetings were again positive and revealed that physicians attended the 1997 Annual Meeting program because of the availability of Category 1 CME credit, a friendly learning environment, speaker quality, and the overall program content.

The Kentucky Medical Insurance Company again sponsored a Risk Management Workshop for Office Assistants, as well as a separate workshop for physicians.

The 1998 KMA Annual Meeting will be held at the Hyatt Regency Hotel/ Commonwealth Convention Center in Louisville. Meetings of the KMA Board of Trustees, House of Delegates, reference committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall, as well as scientific and education exhibits, will be located in the Convention Center. We urge members and their staffs to visit the exhibits. These informal contacts offer numerous opportunities, education reviews, and discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

At this year's Annual Meeting, the general sessions will again be held on Tuesday and Wednesday mornings, and specialty groups will meet on Tuesday and Wednesday afternoons.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for prescribed credit by the American Academy of Family Physicians.

As always, I am very grateful for the efforts of all those individuals who have assisted in the formation of another outstanding program, particularly the Program Committee, specialty group presidents, and program chairs. The Scientific Program Committee always welcomes suggestions for future programs.

James L. Borders, MD
Chair

Report of the Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to be a strong component of the overall success of the Annual Scientific Meeting. The activities of the committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the *KMA Communicator* of the availability of space and provide applications to interested individuals. In 1997, six outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Impaired Physicians Program and the Commission for Children with Special Health Care Needs. We wish to express our appreciation to the following exhibitors at the 1997 Annual Meeting:

— **International Hand Library**
Jewish Hospital Hand and Microsurgery

— **Kentucky Cancer Program**
University of Louisville

— **Make Tobacco Child Proof**
Kentucky Action

— **Outcome Analysis of 140 Cervical Discectomy Surgeries**
John J. Vaughn, MD; G. Chris Stephens, MD; and Janak Talwalker

— **Pituitary Apoplexy and Coagulopathy: Clinical Presentation and Surgical Management**
John J. Guarnaschelli, MD; David A. Petruska, MD; Wayne G. Villanueva, MD; J. Florman, MD; and S. Stawicki

— **Trends in CABG**
Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Erie, MD; Craig A. Nachbauer, MD; Bassam A. Khalil, MD; and Robert 0. Mitchell, MD

I want to take this opportunity to thank the members of the committee for their dedication in serving on the Scientific Exhibits Committee. The scientific exhibits area continues to be a significant and substantial forum for the exchange of necessary and practical scientific information at the Annual Scientific Meeting, and we feel that it is worth all physicians' time to stop at the scientific exhibits area during the Annual Meeting and visit with the scientific exhibitors.

Richard A. Kielar, MD
Chair

Report of the Continuing Medical Education Committee

The work of the CME Committee continues to see expanding activity as the accreditor of organizations providing continuing medical education for physicians in Kentucky. The committee met on four occasions this year and held its annual seminar on April 3, 1998.

In addition, the Committee on Review and Recognition of the Accreditation Council on Continuing Medical Education (ACCME) conducted a site survey of the KMA CME program on August 6, 1997. KMA was granted an accreditation period of four years of continued recognition as an accreditor of intrastate providers of CME. KMA was commended for its effective communications to accredited providers through its newsletter, *CME Quarterly*.

In the ACCME Recognition Report, KMA was asked to modify its appeals mechanism so that organizations that wanted to appeal an accreditation decision could do so to a separate body other than the CME Committee. A change in this policy was made and approved to make the KMA Board of Trustees the final arbiter in an appeals case.

The committee conducted numerous surveys and resurveys of institutions which applied for accreditation of their CME programs. Initial surveys this year were conducted for five institutions. All five applicants were approved and granted a one-year provisional accreditation period, with an interim report to be filed at the midpoint of the accreditation cycle. Surveys were also conducted for eight institutions that had applied for reaccreditation. One institution applying for reaccreditation was granted an accreditation period of four years based on its ability to meet the criteria of the KMA Essentials, which all organizations must demonstrate to become accredited. Five organizations were given a two-year accreditation period, one organization was placed on probation for a one-year period, and one organization's accreditation was withdrawn.

The current accreditation process consists of the committee assisting organizations in developing a working education program and then monitoring organizations' programs through formal surveys. Health care organizations in Kentucky receive accreditation from the committee so they can in turn conduct their own individual CME activities.

The committee adopted a number of new policies this year in the face of a changing accreditation environment and the growing number of nontraditional CME courses. With the increased use of videotape courses,

satellite and Internet programs, and live teleconferences, the committee adopted on August 6, 1997, the ACCME Standards for Enduring Materials and has made these guidelines a part of the KMA accreditation requirements.

At its meeting on April 3, the committee voted to adopt the ACCME revisions to its Essential #7 on joint sponsorship and incorporated the new guidelines into KMA CME policy. Under the new procedures, an accredited institution will still retain responsibility that all Essentials and Standards are met when educational activities are planned and presented in joint sponsorship with nonaccredited sponsors. However, the revision removes language that required "integral" involvement in the planning processes.

The committee also adopted annual reporting from each accredited provider in lieu of an interim report that is requested at the mid-point of each accreditation period. The annual report would allow providers to address any survey report concerns from their last site survey and requests data on total CME activity during the past calendar year. This data is now requested by the ACCME and includes number of programs, number of credit hours, number of physicians and nonphysicians attending, as well as budget information on CME income and expenses.

One of the main topics of discussion at the annual CME seminar this year was the restructuring of the ACCME accreditation process. The ACCME is the national body which, on one hand, accredits state medical societies and other organizations to provide CME, but also empowers and recognizes state medical societies to accredit hospitals and other health care organizations within their state to provide CME activities. Robert R. Goodin, MD, who serves on the Executive Committee of the ACCME as well as being a member of the AMA Council on Medical Education, reported that the new process will allow sponsors to be innovative and more efficient in providing continuing medical education to physicians in the ever changing health care delivery system. The committee looks to the ACCME's restructuring with much interest since we must meet ACCME's guidelines in managing our own CME accreditation system and will make appropriate changes at the state level when the ACCME has a new system to present. It is anticipated that the new system will be reviewed at the state level after January 1, 1999.

Other topics of the 1998 CME Seminar included "Reaching Outside the CME Office," "Preparing for a Site Survey," "The Debate about Joint Sponsorship," and "Using Commercial Support for CME." A popular feature of this year's seminar, which was attended by over 60 CME chairpersons, committee members, and coordinators, was breakout sessions offering different tracks based on the knowledge level of CME personnel in Kentucky.

Thomas K. Slabaugh, MD, attended the ACCME/State Medical Society Conference in which he received information concerning the new accreditation system as well as site surveyor training. The committee plans to include a training session for volunteers who conduct site surveys of accreditation programs at next year's CME seminar.

The committee continued its annual solicitation for nominees for the Educational Achievement Award. Since the criteria for this award was revised several years ago, the field of candidates continues to be extremely strong. Ten nominations were received and considered by the committee. The recipient of the Educational Achievement Award, which was presented at the 1997 KMA Annual Meeting, was Billy H. Andrews, MD, Chairman Emeritus of the University of Louisville Department of Pediatrics.

The committee has an additional meeting scheduled for September and anticipates a very busy year in 1998-99 due to the many impending changes in the accreditation system.

Thomas K. Slabaugh, MD
Chair

Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education convened for two regular meetings this year, both in conjunction with the CME Committee.

The council provides CME credit for association educational meetings, and therefore works closely with the Scientific Program Committee in planning the Annual Scientific Program to ensure that quality education is offered for Category 1 CME credit. The Council reviewed the theme "The Team Approach to Healthcare: The Physician's Role" and the draft of the program for the 1998 KMA Annual Meeting, including speakers, topics, and learning objectives. The council discussed the summary of evaluation forms from the 1997 meeting, and monitored changes which the Scientific Program Committee made based on attendees' comments.

The council continues to monitor the activity of the Accreditation Council on Continuing Medical Education (ACCME) from which it receives its accreditation. The ACCME is in the process of changing the accreditation system to better facilitate physician education in the changing health care delivery system. With the dedicated group of physicians on the council, it is expected that KMA's CME program will adapt readily to any new national accreditation system that the ACCME might implement.

The Council in 1997 approved the seminar on "Domestic Violence: The Role of the Physician in Breaking the Cycle" for three hours of Category 1 AMA PRA CME credit. Since that time, KMA has sponsored four additional Domestic Violence Seminars across the state and is planning a fifth to be held during the 1998 KMA Annual Meeting. We anticipate that almost 500 physicians will have received the required domestic violence CME mandated by state statute from one of these KMA sponsored courses.

In addition, the council approved a videotape of the Domestic Violence Seminar held September 18, 1997, as an enduring material. All the requirements for enduring materials were met, including identification of target audience, needs assessment, specific learning objectives, educational content, qualified faculty, evaluation, and certification.

One new educational opportunity that the council approved for three hours of Category 1 AMA PRA CME credit this year was for the seminar on "What Physicians and Their Staffs Should Know About Fraud and Abuse." Through a study conducted by the KMA Committee on Changing Trends in Medicine and Resolution 97-132, adopted by the KMA House of Delegates, the council was asked to develop a program to inform physicians about the implications of federal and state fraud and abuse laws. Objectives were developed and eight seminars were conducted around the state. A review of evaluations indicates this has been a very worthwhile educational opportunity for Kentucky physicians.

In addition, the council once more approved a request from the KMA Committee on State Legislative Activities to designate four hours of Category 1 CME credit for the 1998 KMA Legislative Seminar held January 8, 1998, in Frankfort.

The council also jointly sponsored the spring meeting of the Kentucky Society of Anesthesiologists in March for eleven hours of Category 1 CME credit. The evaluations showed that the speakers and subject matter were well received and learning objectives were met.

A major discussion throughout the year involved the ACCME revision of Essential #7 on joint sponsorship. Since this policy change directly affects council activity, concern was expressed that the integrity of KMA jointly sponsoring activities would be diminished without the "integral" involvement explicit in the original Essential. However, the council did approve adoption of the new Essential noting that there is still a responsibility on the part of the accredited sponsor to assure compliance with each Essential and Standard of the jointly sponsored program. Procedures were developed, reviewed, and approved by the council to implement the change in policy. A 60-day review period will be upheld on any requests for joint sponsorship.

I would like to thank the members of the council on CME who served as site surveyors for the accreditation program under the auspices of the CME Committee. While it is not the responsibility of the council members to do so, many of them took time out of their busy schedules to lend their expertise in surveying hospitals and other organizations in order to improve their physician education programs.

During the coming year, the council will continue to monitor the work of the ACCME and look to make adjustments accordingly to our own system of providing CME. The council would like to thank the Board of Trustees for permission to serve, and looks forward to increased activity in 1998-99.

James L. Borders, MD
Chair

Report of the Cancer Committee

The Cancer Committee's purpose is to promote the continuing study of patient screening, prevention, education, and treatment of the disease. In this role, the committee serves as a liaison with medical schools, cancer treatment centers, and the Kentucky Chapter of the American Cancer Society. This year the committee has been involved in direct treatment program evaluation efforts to disseminate information on cancer screening and treatment matters in

consideration of broader social and cultural activities to deal with the disease.

Members of the committee this year have been involved in the Primary Care Provider Project. This effort is directed by the Kentucky Cancer Program and is cosponsored by KMA, the Kentucky Academy of Family Physicians, Kentucky Medical Insurance Company, both schools of medicine, the Kentucky Department of Public Health, and the American Cancer Society. The purpose of the project is to increase cervical and breast cancer screening among Kentucky women through CME programs and office-based interventions for family physicians, internists, and OB-GYN physicians.

This program consists of a self-study packet for physicians, which includes a video, a White Paper outlining standards of practice, breast and cervical cancer screening recommendations, sample office tools, a post-test, and an evaluation. At this point, the video has been completed and will be reviewed and critiqued by the committee.

The committee had examined the use of mastectomy versus breast conservation with radiation therapy for breast cancer patients in Kentucky. A few years ago Kentucky was ranked lower nationally in terms of the mastectomy. At that time, multiple factors were attributed to this practice pattern. Patient and physician bias are thought to be two important factors.

One of the committee members had participated in a survey of breast cancer patients in Louisville hospitals between 1994 and 1995. The survey attempted to determine the manner in which the disease was diagnosed, the treatment options provided, and the mode of treatment selected. The study concluded that there still persists a bias toward mastectomy.

Other committee members are participating in a similar study in Paducah that may have different results, which the committee will evaluate and attempt to use for comparisons in the future.

In a related area, the committee reviewed Resolution 96-119, passed by the House of Delegates, which addresses the state mandate to provide information on treatment options to women diagnosed with breast cancer. The committee plans to provide information in this regard to the Kentucky Chapter of the American College of Surgeons and the Kentucky Academy of Family Physicians to heighten awareness.

Noting that cancers of the breast, lung, cervix, and colon are the primary significant diseases in Kentucky, a review of Cancer Registry data shows that the incidence of cervical cancer is an extremely serious health problem that is now receiving inadequate address. The committee will devote future efforts to the promotion of screening, evaluation, and treatment in this area.

Environmental, nutritional, cultural and public health dynamics have strong, although perhaps indirect, impact on the incidence and prevalence of cancer. Tobacco production and consumption, nutrition and lifestyle habits, environmental toxins, and related economic conditions are significant components of disease causative factors. A review of these concerns prompted the committee to seek direction from the Board of Trustees about how the Association might be involved in the address of these areas. The committee felt its responsibility should most appropriately be aimed at direct intervention issues.

As chairman, I would like to thank all of the members for their input and interest, and look forward to continuing our efforts in the coming year.

Michael J. Edwards, MD
Chair

Report of the Physician Workforce Committee

The Physician Workforce Committee did not meet formally this year, but conducted most of its business through phone contact and correspondence.

In May, your committee chair and KMA staff met with the Dean of the Pikeville College School of Osteopathic Medicine, John A. Strosnider, DO. Dr Strosnider shared that part of the mission of the osteopathic school at Pikeville is to "produce graduates who are committed to serving the health care needs of communities in eastern Kentucky and other Appalachian regions."

He reported that the four-year osteopathic school is finishing its first year of operation. Of 350 applicants for the beginning class, 180 students were interviewed for the 60 openings in the first-year class. The average age of this first class is 27, with a range of 21- to 47-year-olds. Of the 60 first-year students, 51 are from Appalachia with 37 from Kentucky.

There are currently 23 faculty in the osteopathic school for the 1998-99 year, with an approximate 10:1 student/faculty ratio. The school is accredited by the American Osteopathic Association (AOA) and is seeking accreditation by the Southern Association of Colleges and Schools (SACS).

Dean Strosnider reported that he is in the process of establishing clinical positions in the Eastern Kentucky area and hopes to have AOA-approved residency programs established in the area for the first graduating class.

The committee is pleased to establish a liaison with Dean Strosnider and the osteopathic school and will follow its progress and growth.

The Physician Workforce Committee will continue to pursue issues at the state and national levels and how they will affect the workforce of physicians in Kentucky. I would like to thank the Board for being permitted to serve and look forward to expanded activity in 1998-99.

Robert R. Goodin, MD
Chair

Report of the Organized Medical Staff Section

The Organized Medical Staff Section (OMSS) works to assure that practicing physicians have a leadership role in the governance of hospitals, other health facilities, and emerging delivery systems. This can best be accomplished through a self governing medical staff that advocates for high-quality patient care and assists the self governing medical staff in maintaining professional standards, ethical principles of practice, and the value of medical services delivered.

As the medical care delivery system and the managed care influence on it continue to evolve, the role of the Organized Medical Staff Section has become less practically defined. Much thought was applied this year to redevelop a practical vision for the section.

Areas that are being explored for more direct involvement by the OMSS are antitrust, marketing physician organizations, negotiations and conflict resolution, the future of organized medical staff, dealing with the disruptive physician, unionization, political and legislative efforts, capitation, emerging information technology, and improving business practices. As the year continues, the OMSS will further consider how its involvement can most effectively represent KMA in these areas.

The OMSS also represents KMA at AMA-OMSS meetings. At the most recent meeting of the AMA-OMSS in June, Kentucky again enhanced its representation at the national level by the reelection of William Monnig, MD, as Secretary of the AMA-OMSS Governing Council. Dr Monnig has maintained and expanded his reputation, stewardship, and outstanding leadership with the OMSS, and our section is justifiably proud of his accomplishments.

At the June meeting, Kentucky representatives took part in discussions on several relevant issues which were subsequently acted on by the AMA House of Delegates.

In the area of physicians' ability to effectively negotiate, the OMSS succeeded in obtaining agreement from the House of Delegates to develop a negotiating entity within organized medicine, with no affiliation with national trade unions. This entity would assist physicians in negotiating collectively with health care payers.

The House of Delegates also agreed to renew its pursuit of the issue of payment delays by HMOs and work to require all health insurance entities to pay within 14 days for "clean claims" when filed electronically.

The emerging use of "hospitalists" was an area of considerable discussion. The House of Delegates directed that efforts be devoted to consideration of the ramifications of hospitalists on the continuity of care, and the ability of primary care physicians to maintain skills and pursue a full scope of practice in situations where hospital privileges are relinquished to hospitalists.

The OMSS vehemently opposed the "Sentinel Event" policy instituted by the Joint Commission on the Accreditation of Healthcare Organizations. The AMA House of Delegates agreed, and has called for a rescission of this policy.

In the area of evaluation and management documentation guidelines from Medicare, the OMSS furthered the arguments that the proposed E & M guides are technically complex, difficult to interpret, and subject patients and physicians to the risk of fraud and abuse allegations for unintended claim-filing errors. The AMA will undertake a number of actions to affect this ongoing problem.

In the area of self-directed actions, the OMSS will work to disseminate the proposed restraint standards for acute medical and surgical patients developed by the JCAHO. The OMSS supports these standards.

The OMSS will work to develop clarification of JCAHO definitions of hospital "leaders" to ensure the preeminence of physician medical staff

leaders as the final determiners of physician care delivery and practice. These efforts are to prevent further erosion of the role and function of the hospital medical staff and reestablish the authority and increasingly important role of medical staff independence.

The OMSS also took the position that, for purposes of legal representation, the hospital and the medical staff be considered separate entities, and that it be considered unethical for an attorney retained by a hospital to officially represent the medical staff as its legal counsel without disclosure of conflicts of interest.

As chairman, I would like to thank those individuals who continue to provide their leadership and input into the KMA-OMSS Steering Committee and for their effective representation of Kentucky's interests at the national level.

John D. O'Brien, MD
Chair

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc, (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians in Kentucky. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipients practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay their loans at a discounted interest rate which is determined yearly. Interest accrues from the date of the loan until the loan is paid in full.

For the academic year 1998-99, the RKMSF offered scholarship loans to 12 new applicants in the amount of $12,000 each, and 21 loans to prior student recipients, said loans totaling $396,000. Last year a total of $312,000 was expended in scholarship loans. In 1996-97 $216,000 was expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted approximately 680 loans. In 1998-99, the fund will have 4 graduating seniors entering primary care residency programs; 9 recipients are currently enrolled in residency programs; and 11 recipients are entering the full-time practice of medicine in 1998. There were 7 recipients who received forgiveness of loans in 1997-98 and 11 recipients completed their financial and/or practice obligations in 1997-98.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying existing educational loans. For each year a physician in the EPGP practices in a critical county, he is granted $10,000 to be used toward an educational debt, with a maximum of $40,000 granted per physician.

One physician is currently participating in the EPGP. Since its inception in 1989, there have been a total of 10 participants in the EPGP. Currently, there are 4 vacancies in the Establish Practice Grant Program.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just over one year, with an average yield of 6.81%.

The Kentucky Medical Association continues to provide financial and other support to the RKMSF which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
Chair

END OF CONSENT CALENDAR ITEMS

RESOLUTION 98-106

Credentialing of Nuclear Medicine Technologists
Jefferson County Medical Society

RESOLVED, that the Kentucky Medical Association endorse the state credentialing of nuclear medicine technologists by the Cabinet for Human Resources.

RECOMMENDATIONS, REFERENCE COMMITTEE B:
Reference Committee B reviewed Resolution 106, Credentialing of Nuclear Medicine Technologists, submitted by the Jefferson County Medical Society.

Reference Committee B recommends that Resolution 106 be referred to the Board of Trustees for further consideration.

RESOLUTION 98-107

Guidelines for Pap Smear Review in Litigation:
KMA Endorsement of College of American Pathologists Guidelines
Fayette County Medical Society

WHEREAS, the Pap smear has been instrumental in an 80% reduction in mortality and morbidity from cervical carcinoma seen over the past 40 years; and

WHEREAS, it is of utmost necessity that this screening procedure remain available to women and integrated with their gynecologic care in order for that high level of prevention to continue; and

WHEREAS, the procedure has recently become the target of many opportunistic malpractice suits such that it now represents the most common basis for action against pathologists and is a major risk for gynecologists as well, with associated increases in direct insurance costs and indirect costs to patients in both money and needless anxiety from "defensive" medical practice; and

WHEREAS, there is a poor understanding of the limitations and subjectivity of the screening procedure by the general public, which leaves judge or jury with no basis to evaluate conflicting "expert" witness testimony; and

WHEREAS, these trends are forcing pathology practices to consider discontinuing the interpretation of Pap smears; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support and endorse the official Guidelines for Review of Pap Smears in the Context of Litigation or Potential Litigation, as approved by the House of Delegates of the College of American Pathologists and accepted by its Board of Directors in February 1998; and be it further

RESOLVED, that the Kentucky Delegates to the American Medical Association work to further endorsement of these same guidelines by the AMA.

RECOMMENDATIONS, REFERENCE COMMITTEE B:
Reference Committee B reviewed Resolution 107, Guidelines for Pap Smear Review in Litigation: KMA Endorsement of College of American Pathologists Guidelines, submitted by the Fayette County Medical Society.

Reference Committee B recommends that Resolution 107 be adopted.

RESOLUTION 98-115

Physician Education on End-of-Life Care
Board of Trustees

WHEREAS, the AMA Council on Ethical and Judicial Affairs has stated that physicians have an obligation to relieve pain and suffering and to promote dignity and autonomy of dying patients in their care; and

WHEREAS, patients suffering from a terminal illness may fear spending the rest of their lives in excruciating, unrelieved pain, and often turn to their physician for compassionate care, comfort, and support; and

WHEREAS, not all physicians may be prepared to understand and execute their professional responsibility in providing and directing the best possible care for their patients who are nearing death; and

WHEREAS, the American Medical Association, in cooperation with the Robert Wood Johnson Foundation, has initiated a project entitled "Education for Physicians on End-of-Life Care," or "EPEC," which is a two-year initiative designed to make a major contribution toward improving the care of dying patients nationwide; now, therefore, be it

RESOLVED, that Kentucky physicians be made aware of the Education for Physicians on End-of-Life Care and the educational opportunities available through the program.

RECOMMENDATIONS, REFERENCE COMMITTEE B:
Reference Committee B reviewed Resolution 115, Physician Education on End-of-Life Care, submitted by the Board of Trustees.

Reference Committee B recommends that Resolution 115 be adopted.

RESOLUTION 98-109

Physician Assistants
McCracken County Medical Society

WHEREAS, Physician Assistants (PAs) have a long history as dependent practitioners providing quality care under the supervision of licensed physicians; and

WHEREAS, the Kentucky Medical Association, American Medical Association, American Academy of Family Physicians, Kentucky Academy of Physician Assistants, and the American Academy of Physician Assistants have each recently reaffirmed their understanding of Physician Assistant practice as requiring the supervision of a licensed physician; and

WHEREAS, the Kentucky Board of Medical Licensure credentials Physician Assistants for practice as certified rather than licensed health care providers; and

WHEREAS, the majority of states credential PAs as licensed health care providers who are required to practice with the supervision of licensed physicians; and

WHEREAS, the qualifications for practice as a certified or licensed PA in any jurisdiction require graduation from an accredited physician assistant training program and successful completion of the national Commission on Certification of Physician Assistants (NCCPA) examination prepared by the National Board of Medical Examiners; and

WHEREAS, a variety of state, federal and institutional regulations and policies regarding credentialing of health care professionals require licensure status for purposes of staff privileges and reimbursement to the practice in which the Physician Assistant functions; and

WHEREAS, many Kentucky physicians are prevented from effectively utilizing the services of Physician Assistants due to the barriers encountered obtaining staff privileges and reimbursement to the practice for services they provide; now, therefore, be it

RESOLVED, that the Kentucky Medical Association endorse legislation, regulations, and agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the physician who supervises the Physician Assistant.

RESOLUTION 98-124

Physician Assistants
Board of Trustees

WHEREAS, since 1975 the Kentucky Medical Association House of Delegates has supported the joint practice of physicians and Physician Assistants under the aegis of the Kentucky Board of Medical Licensure; and

WHEREAS, the House of Delegates supported non-narcotic prescriptive privileges for Physician Assistants who prescribe under protocol with a supervising physician; and

WHEREAS, the KMA recommends that Physician Assistant services be reimbursed to the supervising physician; and

WHEREAS, the KMA opposes federal and state legislation delineating and defining institutional staff privileges for medical and health practitioners and supports the concept that staff privileges be determined on a local level; and

WHEREAS, the Kentucky Medical Association has supported certification of Physician Assistants and opposed licensure for nonphysician practitioners on numerous occasions; now, therefore, be it

RESOLVED, that the 1998 KMA House of Delegates reaffirms its support for certification of Physician Assistants by the Kentucky Board of Medical Licensure; and be it further

RESOLVED, that KMA support reimbursement of physicians for services provided to their patients by supervised physician assistants; and be it further

RESOLVED, that medical institutional policies for purposes of staff privileges for practitioners be established by the local institution in conjunction with medical staff; and be it further

RESOLVED, that institutional staff privileges be determined commensurate with an applicant's education, training, experience, and demonstrated current competence; JCAHO standards; and federal, state, and other government laws and regulations; and be it further

RESOLVED, that a copy of this resolution be forwarded to the Kentucky Board of Medical Licensure, Kentucky Hospital Association, and the Kentucky Association of Physician Assistants.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 109, Physician Assistants, submitted by McCracken Medical Society, and Resolution 124 Physician Assistants, submitted by the Board of Trustees.

Reference Committee B recommends that Resolution 124 be adopted in lieu of Resolution 109.

Mr Speaker, I recommend the adoption of the report of Reference Committee B as a whole.

Mr Speaker, I would like to personally thank the other members of Reference Committee B who have assisted in the formulation of this report. The other members of the committee were: Janice O. Aaron, MD, Louisville; Allan E. Hallquist, MD, Florence; Billy Joe Parson, MD, Somerset; Susan H. Prasher, MD, Ashland; and Ronald E. Waldridge, MD, Shelbyville. I also want to personally thank Ms Michelle Phelps for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE B
W. Lisle Dalton, MD, Lexington, Chair
Jannice O. Aaron, MD, Louisville
Allan E. Hallquist, MD, Florence
Billy Joe Parson, MD, Somerset
Susan H. Prasher, MD, Ashland
Ronald E. Waldridge, MD, Shelbyville

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE C

James F. Beattie, MD, Bowling Green, Chair

22. Report of the Maternal Mortality Study Committee
23. Report of the Committee on National Legislative Activities
24. Report of the Committee on State Legislative Activities
25. Report of the Committee on Professional Liability Insurance
26. Report of the Committee on Care of the Elderly
27. Report of the Public Education Committee

Resolution 101 — Evaluation & Management Guidelines And Fraud & Abuse Investigation (Daviess County Medical Society)
Resolution 104 — Study of Current Antitrust Environment (Jefferson County Medical Society)
Resolution 117 — Gag Clauses (Board of Trustees)
Resolution 118 — Fraud and Abuse (Board of Trustees)
Resolution 120 — Sessions of the Kentucky General Assembly (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee C reviewed the following items and recommends they be filed, by consent of the House, without discussion:

23. Report of the Committee on National Legislative Activities — filed
24. Report of the Committee on State Legislative Activities — filed
25. Report of the Committee on Professional Liability Insurance — filed
26. Report of the Committee on Care for the Elderly — filed
27. Report of the Public Education Committee — filed

Mr Speaker, Reference Committee C would like to express its appreciation to the authors of these reports which have been filed and for their efforts spent in preparing these reports for the House of Delegates. This Committee would like to express special thanks to Drs Barton and Montgomery for their diligent and continued efforts in the area of state and national legislative activities and professional liability insurance. Reference Committee C recommends the adoption of the Consent Calendar as a whole.

Report of the Committee on National Legislative Activities

In March KMA officers, key contacts, and county society officers and staff attended the AMA Leadership Conference. Featured political speakers included President Clinton; Speaker of the House Gingrich; Senators Kennedy, Graham, and Abraham; and HCFA Administrator Nancy-Ann Min DeParle. Other top-notch speakers included Associate Supreme Court Justice Antonio Scalia, General Colin Powell, and AMA officers and lobbyists. The speakers all addressed AMA's major agenda items and appeared to be well versed with AMA's concerns.

The AMA focused upon six legislative priorities during the 105th Congress. AMA's priorities included: health care quality and patient protection; fiscal year 1999 budget; fraud and abuse; private contracting; physician self-referral; and tobacco.

Perhaps no other issue has been more dominating in the political arena than patient protection. The recent US Senatorial race in Kentucky saw all candidates, from both parties discussing problems related to managed care and the patient's right to choose. As noted in the final committee report of State Legislative Chair Wally O. Montgomery, MD, the 1998 Kentucky General Assembly adopted significant patient protection and provider fairness provisions that should be very helpful to Kentucky patients and physicians. Unfortunately, these provisions do not affect patients under "self insured" plans who are exempt from state insurance laws by ERISA and who represent a large percentage of our patients. Therefore, it becomes critical that federal language is adopted to bring these patients, insurers, and employers under the umbrella of state laws and provide fairness and protection to all. Representative Greg Ganske (R) of Iowa has been the chief proponent in Congress on this issue, particularly gag clauses. Representative Ganske has been at odds with Republican leadership over this issue.

In the most recent session, another Republican, Georgian Charlie Norwood, has sponsored a broad-based bill (PARCA) which attacks the abuses of managed care and calls for repeal of the ERISA provision which grants immunity to "self insured" plans.

Norwood's original bill called for including both employer and the insurer, along with providers, in the group which must take responsibility for decisions which cause death or injury to patients. Both President Clinton and Speaker Gingrich indicated at the Leadership Conference that some form of patient protections would pass. There is sharp division within the Republican ranks as it relates to the ERISA exemption. Many conservative Republicans, while sympathetic to legitimate physician and patient concerns, have difficulty in opening up a new avenue for plaintiff lawyers. Representative Norwood has now amended his bill to place the responsibility solely upon the insurer—not the employer. In addition, Norwood has removed provisions relating to nonphysician practitioners that AMA found offensive. We are in hopes that some version of either Norwood or Ganske's proposals will be adopted during the 105th Congressional Session.

In addition to patient protection, provider fairness, and gag clause legislation, efforts are under way at the federal level to support AMA's position that some federal confidentiality legislation be adopted based on the premise that:

- There exists a basic right of patients to privacy of their medical information and records
- "Firewalls" should be constructed to preclude a patient's first consent from applying to all subsequent disclosures
- Exceptions to the requirement for patient consent to disclosure should be minimal and narrowly drawn
- Significant penalties commensurate with the severity of the violation of medical record confidentiality should be in place to discourage such disclosures.

While President Clinton's FY99 Budget does not call for major assaults upon physician payment mechanisms, there are some tactics within the proposed budget that are troublesome. For instance, the budget calls for "user" fees which subtract $1 from payment on any claim that is not submitted electronically. Providers would also be charged a $1 fee for submitting duplicate or unprocessable claims. In addition, managed care plans and fee-for-service providers and suppliers would be charged to cover costs associated with initial registrations and subsequent renewals to the Medicare program. Taken together, this "nickel and dime" approach would net the government $207 million per year from physicians. The AMA has labeled these provisions, calling them a "provider tax."

Fraud and abuse is an extremely contentious issue in Washington as politicians run for cover and seek "painless" ways to reduce the budget while placing responsibility upon others. It has become politically popular among the Administration and both Republicans and Democrats to seize upon the fraud and abuse issue. Washington's definition of fraud and abuse has expanded far beyond the traditional definition of intentionally defrauding the government. Little or no distinction is made between inadvertent errors, legitimate issues of medical judgment, and true fraud. One Administration proposal, the "Centers of Excellence" project enabling Medicare to receive volume discounts on certain surgical procedures, has been labeled as addressing waste, fraud, and abuse. In addition, complying with thousands of pages of complex and cumbersome rules and regulations is overwhelming for the practicing physician. Fraud and abuse have no place in the practice of medicine: nonetheless, reasonable rules of procedure and understandable regulations separating the criminal from the physician who makes honest mistakes or inadvertent errors must be differentiated. Adding insult to injury, in 1997 the Administration sought to repeal the "knowing and willful" standard, whereby prosecutors must prove that the physician has voluntarily and deliberately committed a fraudulent act. Finally, the Department of Justice is currently utilizing the False Claims Act to pursue a number of high-profile investigations to address Medicare billing errors. While hospitals have been the target, the AMA supports efforts to establish reasonable thresholds for triggering the application of the False Claims Act.

During this Congressional Session, we have supported an amendment sponsored by Senator Jon Kyl (R-AZ) to permit physicians and patients to privately contract for health care without government interference. Legislation has been proposed to remove the two-year exclusion requiring physicians to drop out of Medicare for two years if they choose to enter into private contracts with Medicare patients.

Physician self-referral laws (Stark I and II) are in need of change to remove barriers to legitimate arrangements among physicians in the health care sector. The AMA has recommended the following changes:

- Provide exceptions for shared facility services. There is no rational reason to prohibit arrangements which allow physicians to provide services to patients at less cost than if they each have to purchase and operate their own equipment.
- Stark laws should address only "ownership" interests. Only ownership interests should be prohibited. Compensation arrangements would continue to be covered by the anti-kickback law to address inappropriate referrals.
- Revised requirement for direct supervision by physicians. The Stark laws should be amended to provide that the nonphysician be placed under the general, rather than direct, supervision of a physician.
- Exceptions made for community need. There should be a new exception for physician investment in, and referral to, outside facilities in any locale where the Secretary of HHS determines there is a community need for such services and a lack of alternative financing exists.

The final priority of AMA is to adopt legislation granting FDA authority to regulate nicotine and tobacco products. The AMA supports:

- Full authority for FDA to regulate nicotine as a drug, and tobacco products as devices;
- Increase cigarette prices $1.50 per pack over a period of three years;
- Oppose immunity for the tobacco industry;
- Support strong look-back provisions to ensure that the tobacco industry is attempting to reduce its teen market.

During the Association year, the Chair has communicated these and other patient and profession concerns to the Kentucky Congressional Delegation both by letter and direct communication. Kentucky has an outstanding delegation and KMA enjoys an excellent relationship with both our elected officials and their very competent staffs.

Due to committee report deadlines, this report was written and printed prior to adjournment of the 105th Congress. Therefore we are unable to inform you of the final outcome of medicine's agenda. We urge you to continue working with your Congressmen and Senators to assure passage of appropriate legislation that protects patients, enhances access, and reduces unnecessary increases in health and medical expenditures.

On behalf of the entire committee, we thank you for the opportunity to serve.

Donald C. Barton, MD
Chair

Report of the Committee on State Legislative Activities

The Committee on State Legislative Activities is pleased to report the conclusion of another successful session for patients and the profession. The 1998 Kentucky General Assembly adjourned on April 15. During the 1998 Session, 1,709 bills and resolutions were introduced, and KMA followed and closely monitored 237 proposals. While "media wise" social issues were dominant, there were several landmark budgetary issues, particularly in higher and secondary education funding and tax base restructuring, which ultimately may become the true legacy of the 1998 Session. The economic upswing and resultant stabilization of the economy was good news for Kentucky as it has been for the nation.

The KMA House of Delegates established the following legislative priorities for the 1998 Session:

- Patient Protection/Provider Fairness
- Professional Liability Reform
- Health and Safety

For readership purposes, this report is categorized into 12 sections:

1. Patient Protection/Provider Fairness
2. Professional Liability/Plaintiff Lawyers
3. Health and Safety
4. Nonphysician Practitioners
5. Alternative/Complementary Health
6. Medicaid
7. Kentucky Child Health Insurance Program
8. Abortion/Marriage
9. Certificate of Need
10. Other Medical Issues
11. Health Insurance
12. Nonmedical Issues

PATIENT PROTECTION

KMA's primary focus during the 1998 session was to enact Patient Protection and Provider Fairness legislation in accordance with House of Delegates directives. KMA elected to include Patient Protection/Provider Fairness legislation within HB 315, the DeWeese-Damron proposal to reform health insurance, rather than presenting the proposal as a separate and distinct bill. The legislative strategy to include Patient Protection/Provider Fairness in HB 315 was made in consultation with General Assembly leadership, sponsors of the legislation, KMA leadership, and lobbyists. Based on reports from other states and AMA's experience with the 1997 Congress, this turned out to be the correct decision. In 1997 Chambers of Commerce, business, and the managed care industry coalesced to defeat these proposals in Congress and several states.

HB 315 included the following Patient Protection/Provider Fairness components: **(Adopted)**

Patient information from insurers
Requires all insurers to state, in writing, the conditions, terms and information, such as appeals mechanisms, prior authorization procedures, restrictions on access to providers, and other review mechanisms imposed by the insurer.

Financial disclosure to patients
Managed care plans must include lists of physicians, by county, specialty and hospital affiliation, and disclose any financial incentives from the managed care plan and other appropriate consumer information.

Adequate staffing
All managed care plans must have sufficient numbers of primary care, specialist providers, and facility access for their enrollees. Telephone access to the plan must be available, and reasonable standards must be established for waiting times to obtain appointments.

Choice of primary care provider
Adequate choices of primary care must be available. Patients must be allowed to choose their primary care provider from the plan list.

Use of specialists as primary care provider
Plans must permit patients to use specialists as a primary provider when medical conditions warrant.

Prudent layperson definition of emergency
Emergency care must be available without prior authorization, and the definition of "emergency" must be defined in terms a "prudent layperson" understands.

Prohibit gag clauses
Plans are prohibited from limiting providers' disclosure to patients of medical conditions or treatment options.

Once prior approval is granted claim can only be rejected in cases of fraud
When prior approval has been obtained, coverage shall not be retrospectively denied unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information by either the patient or the provider.

Requires managed care to comply with "Do not substitute" provision
When a physician determines that generic substitution of a pharmaceutical product is medically inappropriate, the pharmacist shall prescribe the product the physician determines medically appropriate with the indication "do not substitute." No substitution shall be made without the physician's approval.

PROVIDER FAIRNESS

De-selection/Termination of provider
Each plan must have a policy governing de-selection or termination of a provider from a network. If requested by the provider, the network must provide a reason for termination and hold a hearing within 30 days.

Medical Director
The Medical Director must be licensed in the state in which he or she is employed, and is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan. Decisions to deny, reduce, or terminate a health care benefit or to deny payment for a health service because that service is not medically necessary, shall be made by a physician.

Prohibit "most favored nation" clauses
Insurance contracts cannot contain a "most favored nation" provision unless the Commissioner determines the market share of the insurer is nominal.

Prohibit discriminatory payments to providers
Providers under the guaranteed acceptance program (GAP) shall be reimbursed at rates that are no less favorable than the rates paid to the comparable providers for services delivered to enrollees who do not have a high-cost condition.

Point of service option
Every plan must provide "point of service" or out-of-network benefits to every contract holder that allows a covered person to receive covered services from out-of-network providers without having to obtain a referral.

Any willing provider
Health insurers cannot discriminate against any provider who is located in the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health insurer, including Medicaid and Medicaid partnerships.

Insurer accountability
Insurer accountability for limiting coverage for any treatment, procedure, drug, or device is required. When coverage is denied, a letter provided in a timely manner must identify the person making the denial and give the reason for the denial, and outline alternative services, treatment, or procedures.

PROFESSIONAL LIABILITY REFORM/PLAINTIFF LAWYERS

KMA's other primary legislative goal was tort reform. Due to Patient Protection/Provider Fairness legislation, we spent an inordinate amount of time on the "tort reform" defensive, opposing bills disguised as "social legislation," which in reality were efforts by plaintiff lawyers to expand right of actions.

Wrongful Death/Fetal Personhood

HB 293 Currently, there is no claim for "loss of consortium" where an "unborn child in utero without regards to state of gestation" is involved. HB 293 would have provided for damages to be recovered for the death and "for grief and loss of companionship" from the person who caused it. While the bill exempted physicians and mothers participating in the abortion, it provided no protection for physicians performing OB care, amniocentesis, or prescribing medications. **(Not Adopted)**

Waiver of Sovereign Immunity

HB 667 granted a waiver of sovereign immunity if the state purchased liability insurance or maintained self-insurance. HB 667 would have placed at risk physicians employed by the state or its entities, and physicians serving on state boards and commissions. **(Not Adopted)**

Cause of Action Against a Third-Party Defendant

HB 796 would have eliminated the statute of limitations regarding claims against third-party defendants in malpractice and other personal injury actions. **(Not Adopted)**

Definition of a Person

SB 249 proposed amending statutes to include all human beings from fertilization to death in the definition of a person. **(Not Adopted)**

Parental Consent Prior to Counseling/Treating Minors

SB 294 mandated, "by statute," that physicians obtain consent from parents/guardians before diagnosing, treating, or counseling minors (0-18). **(Not Adopted)**

HMO Liability for patient injury

SB 322 required HMOs making medical treatment decisions to be liable for damages for harm to an enrollee. **(Not Adopted)**

Tort Reform

SB 411 proposed to limit damages and attorney solicitation of clients, regulate attorney fees and punitive awards, provide for structured settlements, and limit noneconomic loss. SB 411 was an effort to reintroduce serious discussion of broad-sweeping tort reform and may be a precursor to tort reform in 2000. **(Not Adopted)**

HEALTH & SAFETY

Motorcycle Helmet Law

HB 106 permits individuals over 21, with a prescribed training course, to operate motorcycles without helmets. **(Adopted)**

Tobacco

SB 146 transferred jurisdiction of minors who illegally purchase tobacco products from the Department of Agriculture to the Juvenile Session of District Court. HFA 3 prohibited purchase of tobacco products by persons under age 18. HFA 4 prohibited persons from providing persons under 18 with tobacco products. **(SB 146 was adopted—but HFA 3 & 4 were defeated.)**

SB 307 prohibits "individual" sales of cigarettes. **(Adopted)**

HB 381 Permitted local governments to enact more stringent penalties to restrict youth access to tobacco. Amended to a "Task Force on Teens and Tobacco." **(Passed the House but died in the Senate)**

HB 561 prohibited possession of tobacco by persons under 18. **(Not Adopted)**

HB 917 Imposed a 25-cent tax per pack on cigarettes for agricultural assistance and diversification. **(Not Adopted)**

Driving Under the Influence (DUI)

HB 327 reduced the allowable BAC from 0.10 to 0.08. **(Not Adopted)**

HB 455 Individuals blowing above 0.18 BAC become Class D felons. **(Adopted)**

Water/Boat Safety

HB 1 establishes age limits for operators to enhance water safety. **(Adopted)**

TB Testing

HB 131 eliminated the requirement for TB testing. **(Adopted)**

Hepatitis B

HB 156 Mandates Hepatitis B test for pregnant women. **(Adopted)**

Closing Restaurants When Imminent Danger to the Public Exists

SB 68 permits health departments to close restaurants without a hearing in the presence of imminent danger to the public. **(Adopted)**

Pick-up Truck/Riders

HB 192 prohibited minors from riding in open vehicles on public highways. **(Not Adopted)**

Bicycle Helmets

HB 254 required minors under age 12 to wear helmets when riding bicycles. **(Not Adopted)**

HB 189 requires a study of health care services to schoolchildren by school personnel not licensed or certified to perform health care services. **(Adopted)**

NONPHYSICIAN PRACTITIONERS

Nurses

HB 187 requires nurses and other licensed, registered, certified, or otherwise regulated employees in a hospital to wear badges or insignia, provided it does not violate sterile procedures. **(Adopted)**

HB 190 Permits ARNPs to sign statements that a child's medical condition prevents or renders inadvisable attendance at school. **(Adopted)**

HB 285 Permits nurses who have successfully completed required training to make determinations of death. **(Adopted)**

HB 603 requires that nursing facilities provide for a criminal record check of nurses as a condition of employment. **(Adopted)**

HB 637 created a "Clinical Nurse Specialist" permitted to prescribe under ARNP guidelines. **(Not Adopted)**

Optometrists

SB 356 mandated direct access to managed care patients by optometrists. **(Withdrawn)**

Athletic Trainers

SB 285 expanded the practice of athletic trainers by permitting them to work with "physicians," rather than "team physicians," and broadly defined the term "athlete." **(Not Adopted)**

Clinical Exercise Physiologist

HB 403 licensed clinical exercise physiologists. **(Not Adopted)**

Physician Assistants

SB 28 permits PAs in a collaborative agreement with a physician to prescribe nonlegend drugs. **(Adopted)**

Pharmacists

HB 649 authorizes pharmacists to assist patients dealing with tests in inventory and which can be sold without a prescription or order. Pharmacists with collaborative agreements and as authorized by the collaborating physician, may perform additional tests and perform appropriate follow up treatment as permitted under the terms of the agreement with the physician. **(Adopted)**

Marriage and Family Counselors

SB 380 licenses marriage and family counselors. **(Adopted)**

Pastoral Counselors

HB 608 requires "fee-based" pastoral counselors to be certified. **(Adopted)**

Paramedics

HB 285 permits paramedics who have completed a required training course to make determinations of death. **(Adopted)**

ALTERNATIVE/COMPLIMENTARY HEALTH

Naturopathy

HB 158 licensed naturopaths, granted prescriptive privileges, allowed them to perform minor surgery, remove foreign objects, perform acupuncture, obstetrical delivery, manipulative therapy, and other medical procedures and services. **(Not Adopted)**

Acupuncture

HB 160 established the Board of Acupuncture/Oriental Medicine. HB 160 authorized "defined" practitioners to use all diagnostic and treatment teachings of acupuncture, oriental, traditional, and modern medical techniques for the prevention or correction of a malady, illness, injury, pain, or other conditions. **(Adopted in Amended Form—See Comments Below)**

Nonconventional Medical Treatment

HB 243/ SB 375 proposed creation of "Complementary or Nonconventional Medical Treatment" practitioners under the Board of Medical Licensure. The legislation redefined dishonorable and unethical conduct and

character and limited the Board of Medical Licensure's ability to discipline alternative practitioners. The Board would have been prohibited from construing as an act of unprofessional conduct a physician's use of any conventional or nonconventional medical care with a reasonable expectation of efficacy in the treatment of human conditions, ailments, diseases, injuries, or infirmities. **(Not Adopted)**

A Committee substitute to HB 160 deleted all contents of 3 legislative proposals (HB 158/160/243) and replaced them with a directive to study benefits and effects of complementary and alternative medicine. The Commission will be composed of various representatives including the Board of Medical Licensure, KMA, three medical schools and others. (Adopted)

MEDICAID

Regional Medicaid Partnerships

SB 305 delayed expansion of the Medicaid regional partnerships outside Regions 3 and 5 until the year 2000 and prohibited placing mental patients under managed care. **(Not Adopted)**

HB 178 exempted mentally retarded persons from Medicaid managed care. **(Not Adopted)**

HB 213 exempted developmentally disabled from Medicaid managed care. **(Not Adopted)**

HB 785 establishes a Medicaid Managed Care Oversight Advisory Committee to provide oversight on the implementation of Medicaid managed care including access, utilization, quality, and cost containment. **(Adopted)**

Mandatory Participation in Medicaid

HB 124 mandated participation in Medicaid, tied to medical license. **(Not Adopted)**

Abolish Medicaid Pre-authorization for Drugs

SB 351 directs that no prior authorization be required for reimbursement of claims involving drugs covered by Medicaid for a period of 12 months, during which time the Drug Management Review Advisory Board may review the product. Safety and high cost measures are included which permit the Medicaid Department to withhold approval if necessary or appropriate. **(Adopted)**

HB 118 required the Administration to request a federal waiver to cover autism and pervasive developmental disorder under Medicaid. **(Not Adopted)**

Fraud and Abuse

HB 227 required physicians participating in the Medicaid Managed Care program to be potentially liable for a felony for "refusing to refer . . . a patient . . . when medically necessary." Such standards were so nebulous that in any instance where an inappropriate result occurred, a physician could be charged with a Class D felony. In other words, if an inappropriate result occurred . . . something medically necessary, i.e., referral, did not occur; therefore the physician is guilty. HB 541 was subsequently introduced to correct deficiencies of HB 227, but never received a hearing. **(Not Adopted)**

Medicaid Coverage for Children 14-18 at 100% FPL (KCHIP)

SB 128 includes a provision calling for the Commonwealth to include all children from 14-18 under the Medicaid program. **(Adopted)**

KENTUCKY CHILD HEALTH INSURANCE PROGRAM (KCHIP)

Eligibility/Funding/Administration

SB 128 in accordance with the 1997 Federal Budget, authorizes KCHIP and funds the state program with matching money for a period of 10 years. Approximately 90,000 of 125,000 uninsured children will be eligible for this free or low-cost program. Kentucky's 1998-99 budget funds KCHIP with $13 million, which in turn will be matched by a $50 million federal subsidy. SB 128 directs KCHIP to be administered by the Department of Medicaid. Health coverage will be available for children under age 18 up to 200% of the FPL. Administration costs are limited to 10%, and a seven-member advisory council will oversee the program. Health departments are permitted to bid for services, and Managed Care Partnerships will be eligible to participate in the program. **(Adopted)**

KCHIP Schedule of Benefits:

Medicaid reimbursement schedules will be used under the program, except for those regions where Partnerships manage the program. Patients may obtain dental and vision care directly. Benefits will match either Blue Cross/Blue Shield federal employee program, state employees' mid-range plan, or a program promoted by the state's largest HMO. **(Adopted)**

ABORTION/MARRIAGE

Abortion

24-hour waiting period/info distribution

HB 85 requires women to wait 24 hours before obtaining an abortion after reviewing various pictures, drawings and other information. **(Adopted)**

Partial Birth Abortion

SB 124 criminalizes the "partial birth abortion" procedure. **(Adopted)**

Licensing Standards for Abortion Facilities

SB 217 requires physician offices where abortions are performed to be licensed. **(Adopted)**

Marriage

HB 11 prohibited same sex marriage. **(Not Adopted)**

HB 13 renders same sex marriages occurring in foreign jurisdictions unenforceable in Kentucky. **(Adopted)**

HB 37 prohibits marriage of persons under 16. **(Adopted)**

HB 702 required statement on marriage license that domestic violence is illegal. **(Not Adopted)**

CERTIFICATE OF NEED

State Health Plan

SB 306 codified the State Health Plan which placed restrictions on physicians seeking exemptions from SHP via the Administrative Regulatory Review process. **(Not Adopted)**

Extend CON

SB 374 provides a six-month extension for projects. **(Adopted)**

CON for Physician Offices

HB 922 Required a physician office/clinic providing some surgical procedures to be licensed as an ambulatory surgery center. **(Not Adopted)**

OTHER MEDICAL ISSUES

Controlled Substance Abuse

HB 115 authorizes the development of a computer network of pharmacies, and a centralized network established through CHR. Eventually, pharmacists, physicians and other providers, by accessing the computer network, will be able to determine if a patient is a "doctor shopper" or an abuser of the system. Following a "date certain" prescriptions for controlled substances may only be written on secure "copy and erasure" proof paper. **(Adopted)**

Charitable Health Care Provider

HB 128 provides for charitable health care providers to render care within their scope of licensure. License granted under reciprocal agreements to an individual from another state/country is evidence of a Kentucky license. Budgets $20,000 for liability insurance that the state will provide. **(Adopted)**

Emergency Medical Services for Children

HB 249 establishes the EMSC to engage in data collection relating to child emergency medical services and trauma care. The Cabinet for Health Services will establish the Emergency Medical Services for Children program. **(Adopted)**

Warranties for New Assistive Devices

HB 410 requires manufacturers of assistive devices to expressly warrant the device against any condition, defect, or malfunction which substantially impairs the use, value, or safety of the device for one year.

Requires that only the manufacturer invoice price be refunded for hearing aids. **(Adopted)**

Breast Cancer Advisory Committee

HB 476 adds a radiologist fellowship-trained in breast diagnostics to membership on the Breast Cancer Advisory Committee. **(Adopted)**

Living Will Expansion

HB 529 permits a person to use a living will to give all or any part of the body upon death for any purpose specified under KRS 311.185. **(Adopted)**

Brain Injury Trust Fund

HB 299 establishes the Brain Injury Trust Fund, funded by imposing fines on vehicle moving violations and DUI. **(Adopted)**

Osteopathy

SB 202 provides tuition to eligible osteopathy medical school students intending to practice in the Commonwealth. **(Adopted)**

Birth Surveillance Registry

SB 336 directs licensed, free-standing birthing centers/general acute care hospitals to give access to medical records to the Birth Surveillance Registry. **(Adopted)**

Confidentiality of Peer Review

SB 268/
HB 711 includes in the definition those proceedings, records, opinions, conclusions, and recommendations made during a designated professional review function which are to be kept confidential and privileged, medical malpractice proceedings, actions arising out of review of credentials or of retrospective review, and actions by an applicant or grantee for staff privileges. **(Not Adopted)**

HEALTH INSURANCE

Autism

SB 63 requires health benefit plans to provide limited health coverage for autism for therapeutic, respite, and rehabilitative care. **(Adopted)**

Emergency Care

SB 227 requires health benefit plans to cover and reimburse expenses for emergency care without prior authorization in certain situations. **(Adopted)**

Cochlear Implants

SB 135 requires health benefit plans to cover cochlear implants. **(Adopted)**

Diabetes

HB 380 requires health benefit plans to cover diabetes. **(Adopted)**

Hearing Screening

HB 456 requires infant hearing screening before being discharged from hospitals and health benefit plans to provide insurance coverage. **(Adopted)**

Unfair Trade Practices/Provider Discounts

HB 457 establishes that it is an unfair trade practice if an insurer fails to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health care provider from the insurer. **(Adopted)**

Cancer Drugs/Treatment

HB 618 requires all health benefit plans not to exclude coverage of cancer drugs when used for an indication other than one on its label if the drug is recognized for that indication in the official compendium or medical literature; requires professional journal publications to meet specific criteria and include documentation regarding drug safety and effectiveness; requires reimbursement if the drug has been prescribed for cancer patients and recognized as safe for cancer treatment. A panel of medical experts, nominated by the KMA, will be appointed by the Commissioner. **(Adopted)**

Women's Health Insurance

HB 864 requires health benefit plans to offer coverage for all stages of breast reconstruction surgery following a mastectomy that resulted from breast cancer if the insurer covers mastectomies; diagnosis and treatment of endometriosis and endometritis if the insurer covers hysterectomies; bone density testing for women aged 35 and older, when indicated by the health provider. **(Adopted)**

NONMEDICAL ISSUES

Lethal Injection/Capital Punishment

HB 27 replaces electrocution as a form of capital punishment with lethal injections. Physicians are prohibited from participating in an execution except to certify death, and only after the condemned has been declared dead by another individual. **(Adopted)**

Annual Sessions

HB 246 a proposed constitutional amendment, permits the General Assembly to convene for 25 days in odd number years. **(Adopted)**

Administrative Regulations

HB 287 allows the public to more effectively participate in the regulatory process. HB 287 requires notice to interested parties, standards for deferral of regulations, more equitable consideration of oral and written comments, and additional public hearings if necessary. **(Adopted)**

For the second consecutive session, we were fortunate in achieving KMA House of Delegates primary legislative goals. As you recall, in 1996 we were able to remove onerous sections of HB 250, the mislabeled Health Reform Act, and begin phase out of the provider tax on physicians. The provider tax is presently .05% and will be completely eliminated August 1, 1999. In addition, we were able to obtain settlement of the $52 million Medicaid lawsuit and increase physician Medicaid reimbursement $26 million annually. In 1998 we were successful in getting Patient Protection/Provider Fairness legislation adopted by the General Assembly.

This year we have attempted to improve the KMA Legislative Handbook by including all known legislative positions of the Association. In addition, we once again conducted the KMA Legislative Seminar in Frankfort and invited every physician member and spouse. Over 200 physicians and spouses availed themselves of this opportunity. On a weekly basis we mailed over 6,000 *Legislative Bulletins*, and blast faxed 3,500 physician offices weekly. The entire KMA legislative team contributed to our success.

On behalf of the Association, we are deeply appreciative of members of the General Assembly and the Administration for their support on many issues of concern to medicine. We thank those physicians and spouses who contacted their legislators on important legislation relating to patient care and the profession. In addition we want to recognize the KMA Alliance for their assistance by operating the Phone Bank in 1998. We are profoundly indebted to Representative Bob M. DeWeese, MD, for his statesmanship and political astuteness in guiding several patient oriented legislative proposals through the 1998 Kentucky General Assembly. Special thanks also to Representative Bob Damron (D) of Nicholasville who co-sponsored and worked diligently with Bob DeWeese to obtain passage of HB 315.

Every Wednesday evening during the Session, President Ken Peters, President-Elect Don Stephens, Secretary-Treasurer Bill VonderHaar, Board Chair Greg Cooper, and Vice Committee Chair Preston Nunnelley met with your chair, lobbyists, and staff to discuss strategy, develop positions on legislation, and to meet periodically with administrative and legislative officials. Their personal sacrifices and efforts in supporting your Chair and KMA's outstanding corps of lobbyists made the 1998 Session a huge success for patients and the profession. Don Chasteen, as Director, Public and Governmental Relations, is the perfect example of a lobbyist par excellence. Also, the expertise of contract lobbyists Bill Doll and John Cooper cannot be matched in Frankfort, nor throughout other states of which I am aware.

In conclusion, I want to personally recognize Bill Applegate and the entire KMA staff for their support in every way. The "Thursday night gang" of Jeanette Thompson, Rick Hahn, and Don Brinley continue to be the unsung heroes of many of our legislative battles. They make sure that your *Legislative Bulletin* gets out each week during the session. These are the folks who provide the support so critical to our Frankfort legislative effort.

Wally O. Montgomery, MD
Chair

Report of the Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance is composed of the KMA Executive Committee and the Chair of the KMA Committee on State Legislative Activities. During the 1998 Legislative Session, Senate Bill 411 was introduced and would have made broad changes to Kentucky's statutes. The bill proposed to limit damages and attorney solicitation of clients, regulate attorney fees and punitive awards, provide for structured settlements, and limit noneconomic loss. Introduction of this legislation was an effort to reintroduce serious discussion of broad sweeping tort reform and may be a precursor to tort reform in the 2000 Session.

Most of the time spent during the 1998 Session on tort reform was defensive, opposing legislation with social overtones, which were, in reality, efforts by plaintiff lawyers to skew the legal system and expand causes of actions that may be brought in court. Five bills were introduced relating either to tort reform or legislation having enormous legal impact upon the practice of medicine.

HB 293 Wrongful death/fetal personhood

Currently, there is no claim for "loss of consortium" where an "unborn child in utero without regards to state of gestation" is involved. The bill, if adopted, would have provided for damages to be recovered "for grief and loss of companionship" from the person who caused the death of the unborn child. While the bill exempted physicians and mothers participating in an abortion, it provided no protection for physicians who performed obstetrical care and amniocentesis or prescribed medications.

HB 667 Waiver of sovereign immunity

Under this proposal, sovereign immunity would have been waived if the state purchased liability insurance or maintained self-insurance. This legislation would have placed physicians at risk who are employed by the Commonwealth or its entities, as well as those physicians serving on various state boards and commissions.

HB 796 Cause of action against a third-party defendant

This bill would have effectively eliminated the statute of limitations regarding claims against third-party defendants in malpractice and other personal injury actions.

SB 249 Definition of a person

This bill proposed amending Kentucky statutes to include all human beings from fertilization to death in the definition of a person.

SB 294 Parental consent prior to counseling/treating minors

This legislation would have mandated that physicians obtain consent from parents or guardians before diagnosing, treating, or counseling minors.

On the federal level, there continues to be a push for some type of liability reform, but most of the discussion centers around product liability. Once such legislation passes the Congress, it must be signed by the President, who has already voiced concerns with the legislation.

While tort reform continues to be opposed, there does seem to be growing support, both at the state and national level, for some type of legislation in this area. The committee will continue to support such legislative efforts.

Wally O. Montgomery, MD
Chair

Report of the Committee on Care of the Elderly

The Committee on Care of the Elderly is responsible for investigating and monitoring trends in care for the elderly, providing information to the membership on these issues, and serving as KMA's representative to elderly advocacy groups.

Managed care continues to evolve. An interesting aspect of managed care is that, while it primarily encompasses mainstream, employed persons and, incrementally, the Medicaid population, managed care has had little direct effect on Medicare to date. Conversely, Medicare reimbursement rates and procedures appear to be the driving force or baseline for nearly all managed care plans. Through the vehicle of the Balanced Budget Act of 1997 (the current federal budget), provisions have been made to begin managed care influence in Medicare in earnest. Changes caused by all these forces are frustrating and anxiety producing for physicians. To elderly patients, however, they are threatening and frightening.

Upcoming options for Medicare are collectively known as Medicare+ Choice. The enabling legislation provides for the commencement of these various options beginning in January 1999, although few will likely commence on that date. Included in the array of options are Medicare HMOs; HMO point-of-service options; provider-sponsored organizations, which may seek state insurance waivers; preferred provider organizations; fee-for-service plans, where Medicare will pay premiums for such plans and the plans will determine reimbursement rates; and medical savings accounts (MSAs). The new provisions allow up to 390,000 people to select the MSA option, which is remarkable for high deductibles with a combined savings account.

Medicaid Managed Care, which Kentucky is now experiencing, provides further concern for the future of medical care financing for the elderly. Medicaid Partnerships are in operation in Louisville and Lexington. Efforts are underway in various stages of progress in other areas of the state. While these Medicaid plans are not directed primarily at the elderly, they do pose two major concerns for aged recipients.

Indigent Medicare-eligible recipients are also eligible for some Medicaid benefits, so-called "cross-over" beneficiaries. This group of people is probably the most vulnerable elderly insured population. Financial "controls" and other indirect barriers that may be imposed by these plans will have a very real effect on elderly patients, a group with the fewest options available.

A second concern is that these Medicaid Partnerships are logical vehicles for Medicare Managed Care operations, and particularly the Medicare HMO option. Should these Partnerships become dominant in Medicare HMO activities, because of the control these plans might assume in the marketplace, elderly patients who are affected will actually have a reduced choice of care plans. The concern here is underscored by the fact that, again, this is a particularly medically fragile population.

A positive note is given the state's current fiscal situation with an unexpected budget surplus. There may be some resulting expansion in services available to the aged or at least in the depth of services in such areas as alternatives to institutional care, transportation, adult day care, and other services.

The committee will continue to monitor the development of these issues and try to acquire and disseminate information to the membership and to other affected groups with whom the committee is associated. As directions develop, the committee will formulate plans for further informational seminars, such as those conducted in the past, and anticipates producing one in the fall of this year.

S. Philip Greiver, MD
Chair

Report of the Public Education Committee

The Public Education Committee has been extensively involved during the 1997-98 Association year. As members recall, the KMA House of Delegates directed the formation of the Public Education Committee and dedicated $25 per year of individual members' KMA dues to fund the committee's activities. The committee is charged with developing and initiating a public education campaign to inform patients, physicians, the general public, as well as other persons who influence health care in Kentucky, regarding positive aspects of the role physicians play in serving the people of the Commonwealth. The committee will develop public education programs which enhance the patient/physician relationship and are adaptable for use by county medical societies and/or physicians' offices.

We continue developing and publishing *MediScope*, the committee's award winning publication. Twenty-five copies of the four-color *MediScope*, the official publication of the Public Education Committee, is mailed to each member of KMA on a quarterly basis. The *MediScope* is an excellent ambassador of KMA and surveys indicate that it is well received and read within the patient community. Each quarter we mail in excess of 120,000 copies to members. In addition, *MediScope* is mailed to nursing homes, hospitals, schools, members of the Kentucky General Assembly, and others. Quarterly circulation of *MediScope* is approximately 7,500.

In 1997 the Public Education Committee established and brought on-line the committee's home page on the Internet at www.mediscope.org. It became an instant success in reaching patients and providing them access to the *MediScope* and committee activities. A one-month study of www.medicscope.org indicated that over 7,261 visitors accessed the page. In addition, we had "hits"

from Panama (5), Canada (12), Netherlands (2), United Kingdom (6), and New Zealand and Australia (1). In the future, we hope to join with KMA and increase access both to our members and patients through the Internet.

Each year, the Public Education Committee grants the Kentucky Medical Association Alliance $5,000 for public education related projects. The following criteria were adopted as guidelines for granting funds to KMAA to establish a statewide public education program:

(1) Proposed projects should be related to public education, enhancement of the patient/physician relationship, or designed to improve the public image of physicians and the profession.
(2) A written request should include the following
    a. Purpose
    b. Plan of action
    c. Objectives
    d. Budget
(3) Projects should be managed by the KMAA Board or designated committee, have statewide implications and be adaptable for use on the county Alliance level.
(4) Following completion of the project, the President of the Alliance or designated chair should provide a summary of the project to the Public Education Committee.

The Public Education Committee is responsible for funds the House of Delegates has so generously provided; therefore, the committee requires careful documentation of projects and expenditures.

In the 1997-98 Association year, the KMAA, in conjunction with the AMA Alliance, launched a joint campaign against violence in the form of "SAVE" or Stop America's Violence Everywhere. The KMA Alliance proposed to purchase and distribute to children in K-3 excellent publications developed by the AMAA called "Hands are not for Hitting" and "I Can Choose," both directed toward conflict resolution rather than resorting to anger and violence. As a result of KMA's grant, along with a Commonwealth of Kentucky grant, over 75,000 Kentucky children in 12 Kentucky counties were reached. Both the logos of KMA and KMAA were prominently displayed on each of the items given to the children.

The committee continues its efforts to expand activities and looks for new projects to support the effort of enhancing communications between physicians and patients. Our consultants are in the process of developing booklets for children to be used in the school systems to combat violence, and promote good health. In addition, we are pleased with our efforts to educate the public on patient protection legislation during the 1998 Kentucky General Assembly.

We urge members of the KMA and other outside entities to contact us if they have suggestions for projects relating to public education which would enhance the physician/patient relationship.

On behalf of committee members, we look forward to serving the profession and we are especially appreciative of the personal and financial support of the KMA House of Delegates and the Board of Trustees.

Preston P. Nunnelley, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association met once during the organizational year on September 17, 1997. The meeting was opened with a reading from the KMA legal counsel regarding the discoverability of deliberations of the Maternal Mortality Study Committee. Section 311.377 of the Kentucky Revised Statutes protects members, participants or employees of committees of any licensed hospital, health maintenance organization, organized medical staff, medical society or designated affiliated medical associations for good faith actions in reviewing and evaluating the competency of conduct of other health care personnel. The proceedings, records, opinions, concludings, and recommendations of any committee, medical staff or other entity are confidential and privileged. Furthermore, they are not subject to discovery, subpoena or induction into evidence in any civil action or any administrative proceeding. The statute does not restrict from discovery any evidence, document, or record which is subject to independent discovery. No person will be permitted or compelled to testify concerning his/her testimony or testimony of others except the defendant in a lawsuit may testify about such matters.

The committee concluded, with this opinion from the KMA legal counsel, that the committee could continue its deliberations without fear of discoverability of its actions.

Dr Steve Davis, Director of Maternal Child Health for the State of Kentucky indicated that the birth certificate had been revised to allow the introduction of a line which reads, "Has this person been pregnant within the last year?" This is a significant advance. Apparently, this information was present in the birth certificates of 1952, but was deleted in subsequent years. It is now part of the current death certificate. This will allow a better screening of patients who have died either in childbirth or within one year of giving birth.

The committee reviewed 12 maternal deaths. These included one death due to a gunshot wound, two deaths due to motor vehicle accidents, one death due to amniotic fluid embolism, three deaths due to pulmonary embolism, one death due to air embolism, one death due to cerebral vascular accident, one death due to Group A streptococcus, and the final death due to septic shock. The committee felt that the death due to septic shock was preventable and that the death due to air embolism was the patient's responsibility as she had engaged in sexual activity which introduced air into the vagina. The remainder of the deaths were nonpreventable.

It was announced that the Division of Maternal Child Health has entered into an agreement with the University of Louisville's Department of Obstetrics and Gynecology to support activities of the Maternal Mortality Study Committee. This support includes a computerized database to collate information and funding for a part-time secretary. This will enhance our ability to collate and maintain an information base. The current evaluation consists of Dr John Petry reviewing birth certificates and acquiring from the death certificates if a maternal death had occurred. When this is ascertained, he then obtains the records or goes to the hospital and reviews the records and issues a report to the committee.

The Maternal Mortality Study Committee shares the concerns of Reference Committee C on maternal mortality. It is our goal to review maternal deaths in a timely fashion; however, when maternal deaths are not reported on the death certificate or not reported to a member of the committee personally, it becomes very difficult to acquire this information. It is the recommendation of this committee that legislative action be taken that mandates maternal deaths be reviewed in a timely fashion and not at the discretion of the hospital in which the death occurred.

The Maternal Mortality Study Committee is planning to have an interim meeting in April 1999 to discuss activities in which the committee should be involved.

Stanley A. Gall, MD
Chair

RECOMMENDATIONS:

1. Legislative action be taken that mandates maternal deaths be reviewed in a timely fashion and not at the discretion of the hospital in which the death occurred.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next reviewed the Report of the Maternal Mortality Study Committee and its Recommendation for legislative action to mandate review of maternal deaths in a timely fashion.

Reference Committee C supports the intent of the authors. However, it was noted that it is KMA policy to oppose mandated peer review. Reference Committee C recommends that this report be referred to the Board of Trustees for further study and appropriate action.

RESOLUTION 98-101

Evaluation & Management Guidelines and Fraud & Abuse Investigation
Daviess County Medical Society

RESOLVED, that the KMA oppose the implementation of the 1998 Medicare Documentation Guidelines for Evaluation Management Services as requirements because they are detrimental to patient care and access and further threaten the confidentiality of patient records; and be it further

RESOLVED, that the KMA work with other physician organizations to

define and confirm what constitutes appropriate documentation; and be it further

RESOLVED, that the KMA use all available means to ensure appropriate safeguards for physicians, so that documentation or inadvertent errors in the patient record that do not meet evaluation and management coding guidelines, in and of themselves, do not constitute fraud or abuse; and be it further

RESOLVED, that the KMA use all available means to ensure that the burden of proof for fraud and abuse lies with prosecution; and be it further

RESOLVED, that the KMA use all available means to ensure that these resolutions be pursued to appropriate ends to protect the welfare of the patients and physicians of the Commonwealth of Kentucky.

RECOMMENDATIONS, REFERENCE COMMITTEE C:
Reference Committee C considered Resolution 101, Evaluation & Management Guidelines and Fraud & Abuse Investigation, submitted by the Daviess County Medical Society. During testimony it was discovered that there was an error in the first Resolved. Reference Committee C recommends deletion of the date "1998" and replacing it with the date "1997". Reference Committee C recommends Resolution 101 be adopted as amended.

RESOLUTION 98-104

Study of Current Antitrust Environment
Jefferson County Medical Society

WHEREAS, the current managed care practice environment leaves physicians at a negotiating disadvantage, particularly for the solo or small group practitioner; and

WHEREAS, due to the subtleties of the legal arena, most physicians are not aware of what collective activities are available and what ones are not without undue risk of severe civil and criminal antitrust penalties; and

WHEREAS, it is unclear to most members as to what is the limit of negotiating assistance that organized medicine can provide to member physicians; and

WHEREAS, physicians, foremost, want to serve their patients in an ethical manner; now, therefore, be it

RESOLVED, that the Kentucky Medical Association study and report on the antitrust environment as it currently relates to medical practice, including what would and would not be allowable collective activity for physicians, and the role of organized medicine on a county, state, and national level; and be it further

RESOLVED, that the KMA be encouraged to present an educational session at the following year's Annual Meeting in order to disseminate this important information to the KMA membership.

RECOMMENDATIONS, REFERENCE COMMITTEE C:
Reference Committee C considered Resolution 104, Study of Current Antitrust Environment, submitted by the Jefferson County Medical Society. Reference Committee C heard testimony from members of the Jefferson County Medical Society and the Board of Trustees and recommends amendment of the Resolveds as follows:

RESOLVED, that the Kentucky Medical Association Board of Trustees consider ~~study and report on~~ the antitrust environment as it currently relates to medical practice, including what would and would not be allowable collective activity for physicians, and the role of organized medicine on a county, state, and national level; and be it further

RESOLVED, that the KMA House of Delegates endorse and support efforts of the AMA to develop the formation of organizations affiliated with organized medicine to assist physicians in collective negotiations; and be it further

RESOLVED, that the KMA be encouraged to present an educational session at the following year's Annual Meeting ~~in order~~ to and disseminate this important information to the KMA membership.

During testimony, it also came to light that the AMA has created a pamphlet entitled *Collective Negotiation and Antitrust, A Guide for Physicians*. It was pointed out that this pamphlet may provide helpful information in the interim before the 1999 House of Delegates meeting.

Reference Committee C recommends adoption of Resolution 104 as amended.

RESOLUTION 98-117

Gag Clauses
Board of Trustees

WHEREAS, so-called gag clauses in contracts between health plans and physicians limit the ability of physicians to communicate openly with their patients; and

WHEREAS, the inability to communicate openly with patients not only affects the physician-patient relationship, but may also endanger the health of the patient; and

WHEREAS, the Kentucky Medical Association passed legislation during the 1998 General Assembly banning gag clauses in contracts between health plans and physicians; and

WHEREAS, some health plans may still place gag clauses in contracts, especially health plans that argue they may be exempt from Kentucky state law because of the federal ERISA law; and

WHEREAS, it is the belief of the American Medical Association that gag clause legislation is not preempted by ERISA, which would force all plans to abide by Kentucky law banning such clauses; now, therefore, be it

RESOLVED, that the Kentucky Medical Association membership be urged to review their contracts with health plans and bring to the attention of the Kentucky Medical Association any contracts that may contain gag clauses; and be it further

RESOLVED, that the Kentucky Medical Association bring to the attention of the Kentucky State Insurance Commissioner any health plans that have placed gag clauses in their contracts with physicians; and be it further

RESOLVED, that the Kentucky Medical Association make available to the public the names of those health plans that have placed gag clauses in their contracts; and be it further

RESOLVED, that if a health plan argues that it does not have to abide by Kentucky state law banning gag clauses because of ERISA, the Kentucky Medical Association consider regulatory, legislative, and legal action.

RECOMMENDATIONS, REFERENCE COMMITTEE C:
Reference Committee C next considered Resolution 117, Gag Clauses, submitted by the Board of Trustees. During testimony, including that of Dr Nancy Dickey, President of the AMA, it was discovered that very few provider agreements now contain gag clauses. However, a more onerous problem is emerging where physicians are being dismissed from plan participation because of their advocacy for their patients.

Reference Committee C recommends that each of the first four Resolveds be amended by adding "/practices" after "gag clauses" in each instance.

Reference Committee C recommends adoption of Resolution 117 as amended.

During a call for discussion, an amendment was offered from the floor of the House on behalf of the Board of Trustees to clarify the language as follows:

RESOLVED, that the Kentucky Medical Association membership be urged to review their contracts with health plans and bring to the attention of the KMA any contracts that may contain gag clauses and instances of dismissal of physicians from plan participation because of patient advocacy, and be it further

RESOLVED, that the KMA bring to the attention of the Kentucky State Insurance Commissioner any health plans that have engaged in these and related activities ~~placed gag clauses in their contracts with~~ physicians, and be it further

RESOLVED, that the KMA make available to the public the names of those health plans that have placed gag clauses in their contracts or have sanctioned physicians for patient advocacy activities, and be it further

RESOLVED, that if a health plan argues that it does not have to abide by Kentucky state law banning gag clauses because of ERISA or can be proven to have taken negative action against physicians for patient advocacy, the Kentucky Medical Association consider regulatory, legislative and legal action.

Resolution 117 was adopted as amended from the floor.

RESOLUTION 98-118

Fraud and Abuse
Board of Trustees

WHEREAS, fraud and abuse in the health care system has become a high profile issue in the last few years; and

WHEREAS, the Kentucky Medical Association supports the investigation and prosecution of anyone who intentionally violates the law; and

WHEREAS, a politically charged atmosphere has been created by the government through the use of misleading statements and inaccurate figures regarding the amount of fraud and abuse in the health care system; and

WHEREAS, such a politically charged atmosphere has created the impression that all physicians commit fraud and abuse intentionally; and

WHEREAS, this politically charged atmosphere has directly hindered the physician-patient relationship by turning patients into investigators for the government; and

WHEREAS, the government has instituted a "bounty system" in which patients and others are encouraged to reports physicians for alleged fraud and abuse, whether or not the physician's action are intentional; and

WHEREAS, the Kentucky Department for Medicaid Services has hired a company known as "Sapient" to investigate and sue physicians for alleged fraud and abuse; and

WHEREAS, Sapient will be paid 25% of all amounts it recovers by conducting such investigations; and

WHEREAS, such an incentive given to Sapient encourages them to investigate and sue physicians who have committed inadvertent errors; and

WHEREAS, the state of Kentucky already has a Medicaid Fraud Unit within the Attorney General's Office; now, therefore be it

RESOLVED, that the Cabinet for Health Services be encouraged to use funds to educate physicians on the appropriate methods of documentation and coding rather than hiring outside companies to investigate and prosecute physicians; and be it further

RESOLVED, that the Kentucky Medical Association officially submit a protest to the Governor and the Secretary of the Cabinet for Health Services regarding the use of outside entities to investigate and prosecute physicians for fraud and abuse; and be it further

RESOLVED, that the Kentucky Medical Association oppose all bounty systems in the investigation and prosecution of fraud and abuse.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C extensively considered Resolution 118, Fraud and Abuse, submitted by the Board of Trustees. Considerable discussion was held on this issue. Secretary of the Cabinet for Health Services, John Morse, gave a presentation to the committee discussing the CHS/Sapient contract to conduct fraud and abuse operations for the Medicaid Program. He advised of his invitation to President Peters to form a working group with CHS to further study potential problems with implementation.

Dr Nancy Dickey, President of the AMA, also testified that while the AMA is opposed to "bounty" type arrangements, there is no AMA policy to that effect, and the AMA would appreciate input from the KMA.

Reference Committee C recommends addition of a fourth Resolved to read as follows:

RESOLVED, that the Kentucky Medical Association requests that the AMA establish a mechanism for collection and review of information on physicians investigated for fraud and abuse.

Reference Committee C recommends the adoption of Resolution 118 as amended.

An amendment to the reference committee addition was offered from the floor of the House on behalf of the Board of Trustees, so that the fourth Resolved would read:

RESOLVED, that the Kentucky Medical Association requests that the AMA establish a mechanism for collection and review of ~~information on physicians investigated for fraud and abuse~~ fraud and abuse investigations of physicians.

Resolution 118 was adopted as amended from the floor of the House.

RESOLUTION 98-120

Sessions of the Kentucky General Assembly
Board of Trustees

WHEREAS, the Kentucky General Assembly (KGA), in accordance with the Kentucky Constitution, convenes on a biennial basis in regular session on even numbered years for a period of 60 days, and convenes ten days in odd numbered years for the purpose of electing officers and assigning committee posts; and

WHEREAS, Kentucky voters are being presented with an amendment to the Kentucky Constitution "to reduce the General Assembly's organization session by five days and to allow the General Assembly to meet in interim session in odd numbered years for twenty-five days"; and

WHEREAS, the KGA's rationale for proposing meetings on an annual basis is to reduce the number of special sessions called by the Governor; and

WHEREAS, governors traditionally utilize special sessions for the purpose of addressing single topics, thereby avoiding tradeoffs on votes by legislators on other legislation; and

WHEREAS, the Honorable Paul Patton, Governor of the Commonwealth of Kentucky, has publicly stated that annual meetings of the General Assembly will not reduce the number of called special sessions by governors; and

WHEREAS, two recent governors have announced opposition to this amendment as an unnecessary expansion of power by the General Assembly; and

WHEREAS, additional legislative days are unnecessary and serve only to provide single issue groups with unlimited time to pursue their agendas; and

WHEREAS, costs to taxpayers, business, industry, and especially associations and other nonprofit groups will dramatically increase as a result of the General Assembly meeting on an annual basis; and

WHEREAS, legislative costs to the Kentucky Medical Association and its membership for additional legislative activities would increase dramatically; and

WHEREAS, the adoption of this amendment would end forever the traditional concept of Kentucky's "citizen legislature," thus creating a full-time Kentucky General Assembly; now, therefore be it

RESOLVED, that the KMA opposes the adoption of the "annual session amendment" that would extend times when the KGA meets; and be it further

RESOLVED, that the 1998 House of Delegates urges physicians, their spouses, and their staffs to oppose and vote "no" on the proposed amendment on the November general election ballot that expands the number of days the General Assembly is in session; and be it further

RESOLVED, that the Kentucky Medical Association communicate and join with other groups and associations in opposing the annual session amendment to the Constitution; and be it further

RESOLVED, that the House of Delegates authorizes the KMA Board of Trustees, at its discretion and at an appropriate level, to assist in funding public information programs to educate the public and voters of future ramifications and costs to taxpayers if the annual session amendment is adopted.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 120, Sessions of the Kentucky General Assembly, submitted by the Board of Trustees, and recommends Resolution 120 be adopted.

Mr Speaker, Reference Committee C recommends the adoption of the report of Reference Committee C as a whole, as amended.

Mr Speaker, I wish to personally thank the other members of Reference Committee C who have attempted to assist this House of Delegates in trying to formulate equitable policies on some very worthy but controversial issues. Other members of this committee are: Gilroy L. Daley, MD, Hazard; Gregory Hazelett, DO, Pikeville; Deborah B. Mattingly, MD, Bardstown; Susan E. Spires, MD, Lexington; and Molloy G. Veal, III, MD, Louisville. Reference Committee C would also like to personally thank Pam Wethington for her assistance in preparing this report.

Respectfully submitted,
REFERENCE COMMITTEE C
James F. Beattie, MD, Bowling Green, Chair
Gilroy L. Daley, MD, Hazard
Gregory Hazelett, DO, Pikeville
Deborah B. Mattingly, MD, Bardstown
Susan E. Spires, MD, Lexington
Molloy G. Veal, III, MD, Louisville

Speaker McClellan called on William Monnig, MD, to present the KEMPAC report.

KMA House of Delegates

September 23,1998

KEMPAC Report

William B. Monnig, MD, Chairman

I am pleased to report that we have met our 1998 goal of 965 members, and as of tonight 975 physicians and spouses are KEMPAC members. 1998 KEMPAC membership has exceeded the 1997 level by 35. While we are extremely pleased with meeting our goal, nonetheless, our job is not done. Less than 15% of physicians are members.

In April, the KEMPAC Board of Directors convened to discuss primary elections. The Board is composed of 12 physicians, and 4 members of the Alliance. Don Barton and Wally Montgomery, your national and state legislative Chairs who work on a daily basis with KMA lobbyists, provide recommendations to the Board during the Board's discussions of individual candidacies. These meetings are not known for brevity, due to the fact we make decisions on 118 state races and 7 national contests. In the primary, we recommend expenditures totaling $34,476 for the various federal Congressional and Senate contests. On the state level, we participated in 17 of 18 Senatorial districts, contributing $16,000 to various candidates. On the House side, we contributed to 64 of the 100 House races. Total dollars recommended was $57,250. That's a grand total of $91,726 for candidate support in the primaries from KMA's political arm. The KEMPAC Board reconvened yesterday morning, for the purpose of reviewing 118 state races and 7 national general election campaigns. We recommended contributions of $20,000 to federal candidates for the House and Senate, and $44,000 to state House and Senate candidates for the Kentucky General Assembly. Total for the General Election was $64,000. The grand total for 1998 primary and general election contributions was $141,250.

As most of you know, AMA and the entire federation of medicine are in the midst of a huge national political battle over patient protection legislation. This is one political fight where we are truly on the side of the patient. There is nothing in patient protection legislation "dollar wise" for physicians. The legislation simply relates to protecting the patient's right to be treated fairly and with dignity. We did not prevail in the U.S. House of Representatives, and quite frankly, the Republican House leadership allowed the HMOs and Chamber of Commerce to write the bill. We are in hopes that the Senate will do a better job, provided there is an opportunity to consider the Patient Protection legislation.

The battles we have fought on the state level in recent years were not easy either. However, we came together to defeat the provider tax and House Bill 250 in 1996. We followed up on those victories by working with Bob DeWeese and Bob Damron in the 1998 Session to adopt patient protection on the state level. We can win on the national level, provided we work with the same degree of intensity—especially on the issues of Patient Protection. It is crucial that we remain vigilant. We must never forget that enemies of this profession and quality patient care never give up.

Political battles cost money. That's where KEMPAC and AMPAC come in. You will never make a better investment in your medical practice than the $100 you contribute to KEMPAC. In most cases, especially on the state level where our practices are most vulnerable, the only contributions to many candidates come from KEMPAC. Approximately one out of four dollars contributed by Kentucky physicians comes from KEMPAC.

Medicine is under unrelenting attack from both internal and external forces. Internecine wars between the various specialties, urban vs. rural, and town vs. gown, cast a dark cloud over the future of medicine. External forces including government, HMOs, managed care, alternative and complementary therapies, and non-physician practitioners, all combined, present a formidable obstacle to this profession. However, neither internal nor external forces will determine our success or failure. Our patients will decide our future, and this profession's future. How we treat and communicate with our patients; how we stand with them in battles with legislatures, government, and big business, HMOs and managed care; and how we work with patients in the General Assembly and Congress will determine our fate. In all of these confrontations, we must forget political partisanship. Fact is every single Republican Congressman from Kentucky voted against us and our patients on the patient protection issue just last month. It is incumbent on each of us to let all of our politicians know, whether Democrat or Republican, that we will not stand by and allow them to ignore this profession and our patients. If Republican Congressmen choose to continue supporting big HMOs, managed care, and Chambers of Commerce at our patient's expense, then we must do what we have done on the state level—organize and defeat them at the polls.

Let me close by thanking each of you for working side by side with us in our battle to preserve this profession. It has been personally rewarding and a pleasure to serve as your KEMPAC Chair for the past two years.

Mr Speaker, this concludes my report.

Tellers David C. Liebschutz, MD, Danville; William H. Mitchell, MD, Richmond; and Ronald E. Waldridge, MD, Shelbyville; were thanked for their efforts.

The Speaker then announced winners of the KEMPAC raffle.

Richard F. Hench, MD, Lexington, Chair of the Kentucky Medical Insurance Company Board of Directors, presented an update on the company's status and activities. He reported that just over 4,000 physicians are insured in Kentucky. He also announced that the parent company now has a new name, Mutual Insurance Company of America (MICOA).

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE D

Judy M. Linger, MD, Georgetown, Chair

28. Report of the Committee on Medical Insurance and Prepayment Plans
29. Report of the Committee on Medicaid Managed Care
30. Report of the Committee to Investigate Changing Trends in Medicine
31. Report of the Young Physicians Steering Committee
32. Report of the Resident Physicians Section
33. Report of the Medical Student Section

Report of the KMA Membership Task Force

Report of the Ad Hoc Committee on Faculty Membership

Resolution 102 — Outcomes Indexed by Severity (Jefferson County Medical Society)

Resolution 108 — Patient-Physician Relationship (Fayette County Medical Society)

Resolution 111 — Universal Health Care (Fayette County Medical Society)

Resolution 113 — Managed Care (Fayette County Medical Society)

Resolution 114 — Membership Recruitment (Board of Trustees)

Resolution 119 — Insurance Department of Enforcement of Late Payment Statutes (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee D reviewed the following items and recommends they be filed, by consent of the House, without discussion:

28. Report of the Committee on Medical Insurance and Prepayment Plans — filed
29. Report of the Committee on Medicaid Managed Care — filed
30. Report of the Committee to Investigate Changing Trends in Medicine — filed
31. Report of the Young Physicians Steering Committee — filed
32. Report of the Resident Physicians Section — filed
33. Report of the Medical Student Section — filed

Report of the KMA Membership Task Force — filed

Report of the Ad Hoc Committee on Faculty Membership — filed

Reference Committee D would like to express its appreciation to the authors of the reports which have been filed for their time and effort spent in preparing these reports for the House of Delegates.

Mr Speaker, Reference Committee D recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans considers problems and issues regarding third-party carriers and serves as a liaison with carriers for KMA. The committee also provides oversight for the KMA group health insurance program with Anthem Blue Cross and Blue Shield.

The major item considered by the committee this year was renewal of the group health insurance plan. In the current situation, volatility with all insurance programs in the Commonwealth following legislative action on insurance reform, options are limited and choices are difficult. With regard to the KMA plan, there are some factors that provide increased difficulty. These include the fact that the KMA plan is a small group and, therefore, allows little negotiating power. Some of the models within the KMA plan, which includes indemnity contracts, are inherently expensive, and the covered individuals include both consumers and providers of insurance-paid care who are sensitive to service payment rates.

Because of insurance reform and the legislatively imposed moratorium, there has been little or no increase in rates for two years. With the presence of these factors, a substantial rate increase was unavoidable.

Some of the alternatives the committee considered to help mitigate the cost situation were: including different coverage options; trying to use different rating schemes; and using different coverage categories, such as employees' coverage only, employee and spouse, and full family.

Additionally, the committee also met with representatives with one other company that had expressed interest in the KMA group. However, this company does not have statewide operations.

Given these facts, together with the absence of any hard, defining cost data, the committee found itself in the uncomfortable position of having inadequate information upon which to base decisions regarding continuation and/or expansion of the KMA plan. For all these reasons, the committee requested of the Board of Trustees that the KMA Insurance Agency, which is KMA's broker and designated agent, be directed to closely follow the situation and obtain the best possible offering. This would include maintenance of existing indemnity policies, but discontinuing the sale of any new indemnity policies. The committee also requested that the Board of Trustees allow the agency to continue to pursue and solicit other appropriate programs and products that would be attractive to members. The Board of Trustees concurred with these recommendations.

The committee also considered rate changes announced to all physicians by Anthem in the early part of the year. These payment changes were listed as percentages of Medicare payments. The committee learned there would be an overall increase in payments in all of the Anthem plans, mostly for evaluation and management procedures. However, there would be decreases in specialty-specific procedures.

Working with the Kentucky Society of Pathologists, the committee considered reimbursement for Pap smears. Last year KMA was successful in persuading the American Medical Association to revise the designation of Pap smear evaluations as an anatomical/clinical service, yet overall reimbursement in Kentucky has continued to decrease. As a result, fewer and fewer pathologists in the state are doing Pap smears. Seeing this matter as an issue of quality of care and proper patient management, the committee recommended to the Board of Trustees to continue to assist the KSP in reaffirming this position on Pap smears and advocating their effort to persuade carriers to evaluate and revise their reimbursement methodologies for this procedure.

Resolution 97-107, adopted by the KMA House of Delegates last September, on the issue of shifting of insurance burdens, was referred to the committee for consideration. This resolution, which was authored by the Jefferson County Medical Society, called on KMA to collect information from members on the shifting of the administrative burdens and costs by insurance carriers to physicians. To comply with the intent of this resolution, the committee published an article in the *Communicator* to solicit information. Response to this solicitation was minimal. Without valid data, the proof of this concern is subjective. The committee will continue to maintain its consideration of this problem but no clear-cut resolution is anticipated.

As chairman of the committee, I would like to thank the members for their interest and input and their efforts on behalf of our work this year.

Donald R. Neel, MD
Chair

Report of the Committee on Medicaid Managed Care

Due to the implementation around the state of Medicaid managed care, KMA created the Committee on Medicaid Managed Care. This Committee monitors and reports to the Board of Trustees and membership on activities of the Cabinet for Health Services, Department of Medicaid Services, and the individual Medicaid partnership regions regarding the development and implementation of regional partnerships. The Committee is composed of physicians from each of the eight Medicaid regions around the state and met twice during the past year.

Kentucky is changing the way Medicaid health care is delivered throughout the state. To replace the KenPAC program, the state has been divided into eight geographic regions, with each region having to develop a Medicaid "Partnership" to deliver health care to the Medicaid population of the region. The state will give each region a specific amount of money each month, depending on the Medicaid population and other factors in the region, and the region will use the money as it sees fit to deliver health care to Medicaid recipients. The largest of these regions, Region 3 (Louisville) and Region 5 (Lexington), have already developed Partnerships and have begun enrolling members in their plans.

The Region 3 Partnership was built around an HMO (owned 51% by the University of Louisville Medical School's Practice Association and the balance coming from Alliant Health System, Jewish Health System, UMC, and various family health centers) and a provider partnership. The HMO organization is the risk-bearing fiduciary agent of the system and the Partnership oversees day-to-day function elements.

The region had development problems after it started operation on November 1, 1997. When the region began, there was a tremendous problem with patient sign-up. Many of the physicians who were formerly large Medicaid providers retained only a small portion of their original patients. Although most of these physicians were able to obtain their previous number of patients, a large fraction of those patients were new. Part of this problem was apparently due to the fact that open enrollment was only for a period of three weeks, which caused a great deal of confusion because patients did not know which physician they were supposed to go to and a lot of patients were getting reassigned according to their zip codes. Also, at the startup of the region, the provider manuals and fee schedules were not available. Even after the initial startup phase there continued to be problems with the required paperwork. The initial sign-up of providers in the region was quite successful; however, since that time, many of the physicians have stopped taking patients. Some physicians have also reported the necessity to hire additional staff to handle the requirements of receiving permission for referrals.

Primary care physicians in Region 3 are paid on a capitation basis by the Partnership, which is averaging $11 per member/per month. The capitation rate for pediatrics is ranging from $5 to $36. Specialists are paid on a fee-for-service basis, with a withhold.

The Region 5 Partnership signed a contract with the state on September 19, 1997, which has an initial term of thirty-two months. The Partnership receives a monthly payment from the state and this payment was negotiated based on the actual historical Region 5 Medicaid expenditures. The state, however, claimed the KenPAC management fee traditionally paid to primary care providers as part of the "savings" to the program, so the rate paid to the Partnership does not include this amount. The state also did not provide the Partnership any portion of the current dollars spent by the Department for Health Services on administration.

Region 5 initially planned to pay physicians 105% of the current Medicaid fee schedule, with a 20% withhold as a temporary risk reserve fund. When it became apparent that funding for the KenPAC management fee would not be included in the state funding of the managed care program, the fee had to be either discontinued or taken out of other funds. The Partnership decided to continue paying a primary care management fee because of the need for primary care physicians in the program. The physician fee schedule, therefore, became 100% of the traditional Medicaid fee schedule, but with a temporary 20% withhold. Region 5 estimates first-year losses to be $11 million, which will be paid out of the withholds from providers.

Other regions are working to establish Partnerships, but none of them have formed one to date. The Trover Foundation, Owensboro Mercy Health System and Community Methodist Hospital are forming a not-for-profit corporation to deliver health care services to the Medicaid population in Region 2. The name of the corporation is Region 2 Development for 2000, Inc. There is also a second corporation being formed called Region 2 Providers/Consumers for 2000, Inc. This corporation will have representatives from the physician community, ancillary providers, health department, dentists, consumers and others identified by state criteria. It is anticipated that the Region 2 Partnership will contract with MedQuest, a locally owned and

operated HMO in Owensboro. The Partnership is not up and running to date, but is looking into using several different methods to distribute payments to providers.

Region 6, which encompasses northern Kentucky, is looking into modeling its Partnership after the Partnership in Region 5, which includes a fee-for-service reimbursement system to all physicians, with a withhold. Region 6 is concerned, however, with whether there will be enough covered lives in the program to make the establishment of a Partnership financially viable. The Partnership, if established, may also look into creating some type of primary care risk-bearing network which would be given a global capitation fee to handle the Medicaid population and the network would then pay physicians however it saw fit.

The Region 8 Steering Committee is a representative group of many providers in the region. This coalition was initially organized by several hospitals, but has attempted to obtain more physician representation on its Steering Committee. The Steering Committee chose AmeriHealth Mercy as the company with whom it will pursue negotiating a contract to become the third-party administrator. Funds for development costs have been raised from several hospitals as well as from contributions from clinics and physicians. These costs will be paid back to investors. Solvency money is also being raised with the hope of eventually paying this back to the investors as well. The region will be divided into three Local Care Delivery Systems with the intent of involving more providers in decision making regarding this program. Physicians will be encouraged to serve on various committees.

The Committee on Medicaid Managed Care has worked hard to keep the membership informed on events in each of the regions. A report has been generated throughout the year and distributed to interested physicians regarding each region's activity.

I wish to thank the members of the committee, as well as others from Regions 3, 5, and 8 who have met with the committee to discuss their projects. I would also like to thank John Morse, Secretary of the Cabinet for Health Services, and Richard Heine, Director of Medicaid Managed Care, for providing the committee with information, as well as their presence at our meetings.

Donald R. Neel, MD
Chair

Report of the Committee to Investigate Changing Trends in Medicine

Last year the Committee to Investigate Changing Trends in Medicine recommended that KMA educate physicians around the state on the potential liability involved in the current politically charged atmosphere of fraud and abuse. With the new investigative resources given to the government, along with the implementation of new Evaluation and Management Codes, the issue of fraud and abuse was timely. Pursuant to the committee's recommendations, KMA conducted seminars around the state on the issue, with over 270 people attending. KMA also published a number of articles and informational items throughout the year to educate physicians, as well as their staffs, on fraud and abuse matters. KMA even drafted an informational paper on establishing a corporate compliance plan for small physician offices.

The KMA conducted a strategic planning process in May and discussed some of the issues that may be of interest to physicians in coming years. New technologies, managed care, employment of physicians, potential legislation and use of allied health professionals in the practice of medicine were all discussed during the session. Since KMA discussed these issues in general terms, the Committee to Investigate Changing Trends in Medicine is waiting to examine the final report of the strategic planning process and determine what physicians believe to be critical issues for the future. The committee plans to meet later in the year to study one of these issues and provide a thorough report.

Marjorie R. Fitzgerald, MD
Chair

Report of the Young Physicians Steering Committee

The Young Physicians Steering Committee focuses on concerns of young physicians, seeks ways for organized medicine to be responsive to those concerns, facilitates communication and interaction among young physicians, and fosters leadership development. Young physicians are defined as those physicians aged 40 years or younger or who are in their first five years of practice.

The Steering Committee continues to focus on membership and the unique needs of our growing demographics within the population of physicians. As the result of President Peters' interest and support, the Steering Committee has been expanded to include a broader geographical mix in total participants. The Steering Committee is now composed of 19 physicians explicitly interested in the group.

A major activity of note this year was the election of Bruce A. Scott, MD, Louisville, to the Board of Trustees of the American Medical Association in the young physicians slot. Dr Scott has been very active in the KMA-YPS, and has served as the sole Delegate of the AMA-YPS to the AMA House of Delegates. Dr Scott is capably representative of young physicians, and we feel he will do an outstanding job on behalf of his Kentucky peers, as well as all of his colleagues nationwide.

We anticipate with interest KMA's ongoing activities in the area of long-range planning. Young physicians continue to be a growing segment of the profession. In Kentucky, young physicians constitute approximately 41% of the total doctor population. While 60% of all eligible young physicians are members, our group also constitutes the largest number of the total nonmembers within KMA. It is our understanding that KMA's immediate and long-term strategic activities will concentrate on young physicians, and we look forward to playing a large role in those activities, along with other elements of KMA.

This year the Young Physicians Section will again convene its annual luncheon meeting during the KMA Annual Meeting on Tuesday, September 22, at noon, in the Keeneland Room of the Hyatt Regency Hotel. We encourage all young physicians to participate in this meeting on topics of current interest. Those wishing to participate should contact the KMA office for further information.

It is our intent to convene a further planning meeting during the fall to develop immediate activities for the next Association year, and input from all young physicians will be encouraged.

On behalf of the Young Physicians Steering Committee, we appreciate the support shown by the Board of Trustees and urgently solicit the interest of our peers.

W. Ford Threlkeld, MD
Chair

Report of the Resident Physicians Section

The Resident Physicians Section has been involved in numerous activities at the state and national levels this year. Representatives from residency programs at the University of Louisville, University of Kentucky, Trover Clinic, and St Elizabeth's form the section's Governing Council, which meets regularly to discuss matters of interest to residents in Kentucky.

The council met four times this year and has had strong representation at the KMA Annual Meeting as well as the AMA Annual Meeting.

The 1997 joint Annual Meeting of the KMA Medical Student Section and Resident Physicians Section, held September 16 in Louisville, dealt with "Will GME Funding Changes Affect Residency Selection?" Robert R. Goodin, MD, Louisville; Alfred L. Thompson, Jr, MD, University of Louisville; and James C. Norton, PhD, University of Kentucky, each spoke about how Medicare reform will affect Graduate Medical Education funding, focusing on the future of medical training and the professional careers of doctors in training.

At the council's January meeting, KMA Lobbyist Don R. Chasteen spoke about legislation before the General Assembly and some general topics of interest to residents. New officers were elected in January as well.

In April tentative plans were made for the upcoming AMA and KMA Annual Meetings. The council drafted a resolution to recommend that the AMA support medical schools teaching reimbursement coding and documentation. This resolution was submitted and adopted at the AMA-RPS Annual Meeting on June 12-13.

In late June, KMA again participated in the Housestaff Orientations at UK and UL. Through these efforts, 67 residents joined the Association. We are grateful to those programs that allow KMA and the county societies to participate at Orientations.

The August 4th meeting reviewed plans for the KMA Annual Meeting.

Jonathan Privett, MD, Delegate to AMA-RPS, reported on activities at the AMA-RPS Annual Meeting.

As president, I want to thank the individual members of the Governing Council for their attendance and input at the quarterly meetings. On behalf of the council, I also wish to thank the KMA Officers, Board of Trustees, and House of Delegates for their continued support and for giving residents the opportunity to have a voice on issues affecting the future of our profession.

James R. Woody, III, MD
President

Report of the Medical Student Section

It is with pleasure that I relay the activities of the University of Louisville Chapter of the KMA Medical Student Section for the 1997-1998 academic year.

The Annual Meeting of the American Medical Association MSS proved to be both interesting and informative. This was a remarkable opportunity to learn the AMA's policy, experience the organization in action, and interact with colleagues. It was also my pleasure to accept a chapter award on behalf of Amy Waltrip's recruitment efforts.

I am proud to announce another successful recruiting year in which we enrolled 100 new members. It is this strong membership which is responsible for the success of the organization. The Outreach program began early this year and already has 23 new members as of this writing.

Our lunch lectureship series was fortunate to have Robert Goodin, MD; Steve Henry, MD; and Ms Jan Hurst as our featured speakers. All delivered dynamic and pertinent speeches concerning the economics, politics, and future of health care.

As one of our chapter's philanthropies, we sponsored a food drive for Kentucky Harvest. The first- and second-year medical students donated hundreds of canned goods to this worthy organization. In addition, we sponsored the Central High School Mentoring program. This year we had over forty members acting as resources for these motivated high school students interested in pursuing a health care career. In an effort to curtail adolescent use of tobacco, we are initiating a SMART program. Under the guidance of Kate Wilson, President 1998-1999, medical students will deliver slide presentations and lead discussions in 4th, 5th, and 6th grade classrooms.

These projects were brought to fruition and achieved success due to the efforts and commitment of Shannon Lynn, Vice-President; Molly Becherer, Secretary; Becky Sarver, Treasurer; Kate Wilson, First Year Representative; and all of the student members.

Thank you to the Kentucky Medical Association for acting as a resource and your commitment to the success of our student section.

Bryce E. Schuster
President

Report of the KMA Membership Task Force

The KMA Membership Task Force, which was appointed by the Board of Trustees in April 1997, met on two occasions this year. The task force is composed of a broad representation of the membership population; eg, women, rural practice, young physicians, academic, international medical graduates, employed physicians, residents, and medical students.

The overall objective of the Membership Task Force is to (1) strengthen membership through recruitment of new members and retention of existing members and (2) encourage an increased level of participation in Association activities; thereby establishing a stronger, more cohesive community of physicians working together for the common purposes of the Association.

To achieve these goals, the task force has concentrated its efforts in a number of areas, including communications and advocacy issues.

The task force feels that KMA needs to move forward in technological communications with members, committees, and leadership. This year, KMA approved the development of a web site and implementation to get this online prior to the 1998 KMA Annual Meeting. The web site will serve as a resource center for members on areas such as legislation, legal issues, continuing medical education, the Annual Meeting, and important links to other medical sites. Future plans include a statewide roster of KMA members and calendar of activities. The web site will also serve as a tool to encourage nonmembers to participate. KMA's web address is www.kyma.org and the task force welcomes suggestions from the membership on ways to enhance the web site.

In the area of advocacy and vision, the task force continues to discuss the role of focus groups to determine what physicians (members/nonmembers) want and need from their professional association. Because of the strategic planning efforts underway this year by KMA President C. Kenneth Peters, MD, the task force felt the information gleaned from this effort would help to determine a future direction with the use of focus groups and/or statewide member surveys.

A number of benefits/services that are exclusive to members were reviewed by the task force, but no recommendations were made on any specific vendor or program.

The Membership Task Force also reviewed a request from the Kentucky Academy of Physician Assistants (KAPA) for its members to be given membership status within KMA. After discussion, the task force recommended to the Executive Committee that KAPA be offered the opportunity to be an "Official Observer" of the KMA House of Delegates.

We thank the Board for its confidence and freedom to explore avenues that may have far-reaching implications for the future direction of KMA and welcome input from members of the House of Delegates in this undertaking.

Ardis D. Hoven, MD
Chair

Report of the Ad Hoc Committee on Faculty Membership

The Ad Hoc Committee on Faculty Membership was appointed by the Board of Trustees to try to enhance membership among faculty physicians. A secondary task was to work to maintain the significant increase in membership realized in 1996 among faculty members at the University of Kentucky.

The committee is composed of two representatives from the University of Kentucky faculty, Daniel E. Kenady, MD, and Barbara A. Phillips, MD; and two representatives from the University of Louisville faculty, Susan Galandiuk, MD, and Frank B. Miller, MD. In addition, acting as advisors to the committee were Mrs Carolyn Kurz, Executive Vice President of the Fayette County Medical Society; Mr Lelan Woodmansee, Executive Director of the Jefferson County Medical Society; and the KMA staff. Donald R. Kmetz, MD, Dean of the University of Louisville School of Medicine, and Emery A. Wilson, MD, Dean of the College of Medicine at the University of Kentucky, were also consulted as ex officio members.

The committee held several meetings. It was quickly determined that objective information was needed to learn the perceptions of faculty physicians about KMA, to try to determine those areas they felt required expansion, their particular needs, and an idea about the level of awareness of services already provided by KMA and the involved county medical societies (Jefferson and Fayette).

To this end, a survey instrument was developed and mailed to all faculty physicians in the summer of 1997. The response rate was approximately 20% from each school. Separate surveys were sent in each location to reflect the unique services and benefits also available from the affected county medical society. The results were interesting.

Members in both areas were relatively aware of the services and benefits provided and strongly supportive of both KMA and their county medical society. Nonmembers were much less aware of these items. While many of the respondents listed unmet needs, some concerns common to both schools were identified in areas where KMA and the counties are significantly involved.

In summary, these common areas were:

- KMA should seek expanded support for medical students and graduate medical education
- KMA should work with payers on faculty reimbursement issues
- KMA should work to promote scientific research
- A general concern was physicians workforce issues
- Interest was expressed in participation in national medical policy development
- KMA should increase its work on public health issues
- More opportunities should be provided for participation in legislative policy activities

In follow up to this survey, a lengthy letter that discussed the survey results was sent to all respondents in December by President Peters.

The ad hoc committee determined that enhanced communications with faculty members was an area of focus. To this end, a series of e-mail messages were sent to all faculty members through the offices of both deans, and there was positive feedback, which was identified through inquiries about information contained in these messages. Using the e-mail vehicle, the ad hoc committee helped coordinate the solicitation of members to serve on various KMA committees and also solicited nominations for national-level appointments.

Later in the year and in further follow up to the survey, in particular, and the committee's overall charge, in general, brochures were developed for each medical school community, in conjunction with each of the county medical societies, and were mailed. These brochures summarized benefits and services and invited inquiries, and the brochures were felt to be an additional and helpful targeted communications effort. The brochures were specifically used with the annual membership solicitation effort, and were targeted to physicians renewing their membership, former members who had not renewed, and nonmembers.

At the time of this writing, final membership figures are not available. However, it appears that the membership rate among faculty physicians for 1998 has kept pace with the level of 1997, and may have somewhat exceeded it. This is particularly gratifying because 1998 membership participation, particularly at the University of Kentucky, was completely voluntary.

In summary, the ad hoc committee feels this has been a very worthwhile project, and recommends that efforts focused on faculty physicians be continued in the areas of special communications, solicitation for participation in specific KMA committees and activities, and development and presentation of distinct seminars in areas such as medical research activities. The ad hoc committee further recommends that these suggested efforts be pursued through whatever new or existing group within the KMA structure that may be appropriate.

Preston P. Nunnelley, MD
Chair

END OF CONSENT CALENDAR ITEMS

RESOLUTION 98-102

Outcomes indexed by Severity
Jefferson County Medical Society

WHEREAS, hospitals, managed care companies, and some physician credentialing organizations routinely collect financial data on treatment costs per case generated by physicians, sometimes termed "outcome studies"; and

WHEREAS, such cursory information does not reflect case difficulty or severity of illness, yet may be used to exclude physicians from participating in insurance/service delivery programs; and

WHEREAS, such economic measures of treatment and outcomes are inappropriate to patient care and are an illegitimate and improper indication of care results or physician competence; now, therefore, be it

RESOLVED, that the Kentucky Medical Association report on the activities of the American Medical Association, the Kentucky Department of Insurance, and involved medical specialty organizations to identify or develop a model uniform case severity system at the next House of Delegates meeting; and be it further

RESOLVED, that KMA urge any entity that collects physician-specific, cost-per-case data to utilize a case severity classification system based on the overall health of the patients involved, and that such entities make their source data available for review by physicians.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D reviewed Resolution 102, Outcomes Indexed by Severity, submitted by the Jefferson County Medical Society.

Reference Committee D recommends that the second Resolved be amended to include the words "and the formulas used to define quality of outcomes" after the phrase "source data." Then the Resolved would read:

RESOLVED, that KMA urge any entity that collects physician-specific, cost-per-case data to utilize a case severity classification system based on the overall health of the patients involved, and that such entities make their source data and the formulas used to define quality of outcomes available for review by physicians.

Reference Committee D recommends that Resolution 102 be adopted as amended.

RESOLUTION 98-108

Patient-Physician Relationship
Fayette County Medical Society

WHEREAS, the proper relationship of the physician to his/her patient has been inappropriately usurped by nonphysicians, lay members of government, and utilization management bodies of private and public healthcare corporations; and

WHEREAS, the physician is in the most credible position to judge quality of care and cost effectiveness, with accurate information about the management of a patient's care; now, therefore, be it

RESOLVED, that it shall be Kentucky Medical Association policy that the physician should be in the focal position of directing medical care to produce an outcome in the best interest of the patient, appropriate to the patient's situation, in the most timely and cost-effective manner possible, adhering to established principles of ethics, and for fair and reasonable compensation.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D considered Resolution 108, Patient-Physician Relationship, submitted by the Fayette County Medical Society. Following discussion of this matter, Reference Committee D recommends that the word "focal" be changed to "primary" in the first Resolved.

The Committee also recommends the addition of a second Resolved, which would read:

RESOLVED, that the KMA Leadership meet with health insurers, utilization review organizations, and government agencies to develop streamlined processes for meeting the goals of high quality, physician-directed, affordable medical care.

There was a strong feeling expressed in testimony and among members that KMA should take steps to defend the patient-physician relationship. The second Resolved calls for such action.

Reference Committee D recommends that Resolution 108 be adopted as amended.

RESOLUTION 98-111

Universal Access to Health Care
Fayette County Medical Society

WHEREAS, there remain approximately 41 million Americans and 500,000 Kentuckians who are uninsured without health care "coverage," and this number is expected to continue to grow; and

WHEREAS, minimum standards of health care quality are meaningless so long as people can be excluded altogether from any care; and

WHEREAS, studies have shown uninsured citizens fare more poorly than insured citizens in terms of services rendered, death rates, and age of death; and

WHEREAS, critically ill, uninsured citizens of all ages must rely on an informal, unreliable and often untimely program of catastrophic health care operated by hospitals and physicians, largely on a voluntary basis; now, therefore, be it

RESOLVED, the Kentucky Medical Association reaffirms its support of the concept that society has an obligation to make access to health care available to all of its citizens, regardless of ability to pay; and be it further

RESOLVED, that the Kentucky Medical Association affirms its support for a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D next considered Resolution 111, Universal access to Health Care, submitted by the Fayette County Medical Society.

Reference Committee D recommends that Resolution 111 be adopted.

RESOLUTION 98-113

Managed Care
Fayette County Medical Society

WHEREAS, managed care is defined by the American Medical Association as "those processes or techniques used by any entity that delivers, administers and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or

outcomes of such services provided to a defined enrollee population"; and

WHEREAS, complexity in medicine demands management, since deepening complexity generates rising cost, which can be controlled by process management techniques; and

WHEREAS, traditional medical care and managed care are in a state of continuous evolution and can be improved by physician influence; and

WHEREAS, medical leadership is necessary to preserve the mission and science of health care; and

WHEREAS, passive resistance or active opposition to managed care excludes physicians from participation in the formation and function of medical management mechanisms; now, therefore, be it

RESOLVED, that the Kentucky Medical Association should encourage physicians to become more involved in the design, implementation, and operation of managed care systems and work to modify the faults of managed care, making it better serve the interests of patients and physicians.

RECOMMENDATIONS, REFERENCE COMMITTEE D:
Reference Committee D considered Resolution 113, Managed Care, submitted by the Fayette County Medical Society.

Reference Committee D recommends that Resolution 113 be adopted.

RESOLUTION 98-114

Membership Recruitment
Board of Trustees

WHEREAS, membership recruitment and retention was identified as a major priority in the strategic planning process; and

WHEREAS, while membership in KMA is significant when compared to other states, approximately 26% of the physicians in Kentucky eligible for membership in KMA are not members, but are beneficiaries of the advocacy efforts of the Association; and

WHEREAS, KMA is undertaking a member-get-a-member peer recruitment project from September 1998 through March 1999; and

WHEREAS, peer-to-peer recruitment is the most effective member recruitment tool; now, therefore, be it

RESOLVED, that the KMA House of Delegates endorses and supports the member-get-a-member campaign and encourages all KMA members to vigorously urge nonmember colleagues to join the House of Medicine; and be it further

RESOLVED, that each member of the KMA House of Delegates personally commit to recruiting at least one nonmember during the coming year through the member-get-a-member campaign.

RECOMMENDATIONS, REFERENCE COMMITTEE D:
Reference Committee D considered Resolution 114, Membership Recruitment, submitted by the Board of Trustees.

Reference Committee D recommends that Resolution 114 be adopted.

RESOLUTION 98-119

Insurance Department Enforcement of Late Payment Statutes
Board of Trustees

WHEREAS, KRS 304.12-235 requires third-party payers to forward payment of claims within 30 days of submission or pay interest on the unpaid claim of 12%; and

WHEREAS, many third-party payers do not pay claims within the required 30 days and do not pay the required interest; and

WHEREAS, many third-party payers assert that sufficient documentation or an adequately prepared claim form was not filed and, therefore, refuse to pay the claim until the alleged problem is resolved by the physician; and

WHEREAS, physicians are not told of an inadequately prepared claim until they inquire with the third-party payer why a claim has not been paid; and

WHEREAS, it is the duty and obligation of the Kentucky Department of Insurance to enforce statutes and regulations governing insurance and third-party payers selling health insurance, providing third-party administrative services to Kentucky clients, and others engaged in the payment of covered health benefits; now, therefore, be it

RESOLVED, that KMA introduce legislation to require third-party payers to notify physicians within 30 days if a claim is inadequately prepared; otherwise, the claim is presumed valid; and be it further

RESOLVED, that KMA introduce legislation to require third-party payers to pay electronically submitted claims within 15 days; and be it further

RESOLVED, that KMA introduce legislation defining a "clean claim" for purposes of this issue; and be it further

RESOLVED, that the Department of Insurance be encouraged to track the number of complaints on each third-party payer and make such information available to physicians and the public; and be it further

RESOLVED, that KMA explore all legislative and legal means to ensure that this law apply to all third-party payers, including those covered under the federal ERISA law; and be it further

RESOLVED, that KMA urge appropriate authorities to enforce existing laws.

RECOMMENDATIONS, REFERENCE COMMITTEE D:
Reference Committee D considered Resolution 119, Insurance Department Enforcement of Late Payment Statutes, submitted by the Board of Trustees.

Reference Committee D recommends that Resolution 119 be adopted.

Mr Speaker, Reference Committee D recommends the adoption of the Report of Reference Committee D as a whole.

Mr Speaker, I want to personally thank the other members of Reference Committee D who have attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the Committee were: David T. Allen, MD, Louisville; Kirsten L. Cooper, MD, Madisonville; Robert J. Emslie, MD, Bowling Green; John D. Stewart, II, MD, Lexington; and David Watkins, MD, Henderson. I would also like to thank Debbie Cunagin for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE D
Judy M. Linger, MD, Georgetown, Chair
David T. Allen, MD, Louisville
Kirsten L. Cooper, MD, Madisonville
Robert J. Emslie, MD, Bowling Green
John D. Stewart, II, MD, Lexington
David Watkins, MD, Henderson

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE E

John S. Cave, MD, Henderson, Chair

34. Report of the Committee on Maternal and Neonatal Health
35. Report of the Technical Advisory Committee on Physician Services (Title XIX)
36. Report of the Committee on Community and Rural Health
37. Report of the Committee on Physical Education and Medical Aspects of Sports
38. Report of the Committee on Child and School Health
39. Report of the Judicial Council
40. Report of the Interspecialty Council

Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan
Report of the Ad Hoc Committee to Recommend a Section on International Medical Graduates
Resolution 103 — Medicaid Outpatient Testing (Jefferson County Medical Society)
Resolution 110 — Confined Animal Feeding Operations (CAFOs) (John A. Patterson, MD, MSPH)
Resolution 122 — Vaccine for Children (VFC) (Board of Trustees)
Resolution 123 — Universal Vaccine (Board of Trustees)

ITEMS FOR CONSENT
Reference Committee E reviewed the following items and recommends they be filed, by consent of the House, without discussion:
34. Report of the Committee on Maternal and Neonatal Health — filed

35. Report of the Technical Advisory Committee on Physician Services (Title XIX) — filed
36. Report of the Committee on Community and Rural Health — filed
37. Report of the Committee on Physical Education and Medical Aspects of Sports — filed
38. Report of the Committee on Child and School Health — filed
39. Report of the Judicial Council — filed

Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan — filed

Report of the Ad Hoc Committee to Recommend a Section on International Medical Graduates — filed

Reference Committee E would like to express its appreciation to the chairs and members of these committees for their efforts in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee E recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Maternal and Neonatal Health

The Committee on Maternal and Neonatal Health considers issues related to quality medical care for mothers and newborns. The committee also advises the Board of Trustees and House of Delegates on matters relating to maternal and infant health. A number of issues were considered this year.

Last year the committee reviewed an interdisciplinary report on a treatment protocol for management of infants with apnea. The House of Delegates subsequently approved this report. Since the Annual Meeting, the report was presented at the Pediatric and Newborn Symposium at the University of Louisville where it was well received, and the Maternal and Child Health Department of the Cabinet for Health and Human Resources has also endorsed the document. The department is searching for funding from the March of Dimes to further publish and disseminate the report.

Information was reviewed on the "Adopt-a-Physician" program with which this committee had some initial involvement, but another KMA group now considers. In this program KMA, together with the Department of Education, works to provide interested schools with a volunteer physician consultant from the community. A survey of local school systems produced 77 responses from areas interested in participating, and KMA surveyed physicians to determine interest. Many physicians who expressed interest had no community response in their areas.

This program is of interest to the Committee on Maternal and Child Health because of a further concern with including parenting and family life in school curricula. Physicians involved in the Adopt-a-Physician program might be able to influence site-based councils to include this matter in local curricula. A similar program is conducted by the Jefferson County Medical Society in Jefferson County, the "Schools of Excellence." Ongoing efforts by KMA and the Department of Education are being conducted to further expand and develop this effort.

Individual members participated in the Governor's Conference on Teen Pregnancy. The state at that time had implemented some media campaigns directed to teens encouraging them to become involved in personal development and avoid risk-taking behavior.

It was noted at the conference that health education represents only 3.5% of KERA testing. With no more test weight, there is little influence on local school administrations to increase health education curricula. It was also noted that while the teen pregnancy rate in Kentucky is reduced from previous years, it remains above the national average.

In a related area, the committee considered activities by the KMA Alliance in areas involving teenage mothers and health issues. The committee noted that Mrs Gil Daley of Hazard had initiated a particularly worthwhile program entitled "Growing Healthy." Dependent on local fundraising, this program uses booklets provided to all grades in the local school system that cover health education, bodily systems, emotional wellbeing, and so forth. The program emphasizes self-esteem and self-protection and includes teaching materials. Through the efforts of the Alliance last year and the KMA Public Education Committee, copies of the booklet *I Can Choose* were distributed throughout the state that focused on child health and related matters.

The committee discussed the Kentucky Children's Health Insurance Program (K-CHIP), or "Kiddie Care." This federal program provides $24 billion nationally over the next five years to extend medical insurance to children that are not eligible for Medicaid, up to 200% of the federal poverty level, at the option of states. Through the Department of Maternal and Child Health, some individuals have been working on this issue for the past few years. Because the program includes a requirement for state matching funds, Kentucky will have to develop legislatively approved operating guidelines, as well as matching finances.

Discussions were also held by the group concerning mandatory continuing medical education for physicians in the area of domestic violence and HIV issues, the influence of maternal weight gain as a health indicator and its effects on neonatal wellbeing, the issue of partial birth abortions, and Medicaid managed care programs being initiated in the state.

The committee plans to resume its activities in the fall, to include an address of issues arising out of the legislative session.

As chairman, I would like to thank all of the committee members for their interest and input and voice a special note of thanks to the immediate past chairman of the committee, J. Gregory Cooper, MD, for his dedicated leadership and interest.

Ronald J. Lubbe, MD
Chair

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The Technical Advisory Committee on Physician Services (Title XIX) (hereinafter TAC) is one of 11 provider groups represented on the Advisory Council for Medical Assistance, which advises the Secretary for Health Services on Medicaid issues. The TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Medicaid program. If the TAC determines that the issues discussed require action, they are presented in a report to the Advisory Council for action. The TAC meetings are subject to the provisions of KRS 61.805-61.850, the Kentucky Open Meetings Law, which requires all TAC meetings to be open to the public and scheduled to allow effective public observation and media coverage.

The TAC did not meet during the past year. There were, however, issues within Medicaid that were addressed by other KMA committees and leadership. The Medicaid managed care program, in which each of the eight geographic regions around the state are supposed to establish a Medicaid Partnership, has been instituted in Regions 3 and 5 (Louisville and Lexington). For a more detailed analysis of that program, the report of KMA's Committee on Medicaid Managed Care should be consulted.

The Department for Medicaid Services sent reenrollment paperwork to physicians around the state and had each of them sign a new provider contract. The contract, however, was quite ambiguous in regards to many terms and conditions; thus, KMA legal counsel provided an in-depth analysis of the contract and this analysis was made available to KMA membership. KMA President Ken Peters, MD, also wrote the Department and asked for clarification of many of the terms of the contract. The Department's response was also made available to the membership.

Allied health professionals within the Medicaid system continue to be an issue with Medicaid. Nurse practitioners once again requested the status of "primary care providers" within the Medicaid system, which has been opposed by the committee in the past. Nurse anesthetists also requested reimbursement at 95% of physician reimbursement, despite their lack of training and experience compared with physicians. Physician assistants have requested that physicians be reimbursed by Medicaid for physician assistant services, which is currently prohibited by the Department.

While the future of the physicians' TAC is somewhat murky because of the institution of Medicaid managed care, the committee continues its efforts to provide a meaningful forum for Kentucky's physicians to present their views and ideas in providing quality medical care to Kentucky's indigent population. I would like to thank the committee members for their dedication to this effort.

Salem M. George, MD
Chair

Report of the Committee on Community and Rural Health

The Community and Rural Health Committee met on one occasion this year to discuss various health and safety issues.

A major initiative of the committee this year occurred under the auspices of the Subcommittee on Domestic Violence. The subcommittee's "Model Health Care Protocol on Abuse, Neglect, and Exploitation: Child, Spouse/Partner, Adult and Elder" which was mailed to member physicians in March 1997, was approved by the Governor's Council on Domestic Violence and the Kentucky Board of Medical Licensure as the curriculum for domestic violence training for physicians.

In order to meet the domestic violence CME requirements for Kentucky licensure, physicians must attend an approved three-hour course that uses the KMA "Model Health Protocol on Abuse, Neglect and Exploitation" as its training curriculum. The subcommittee reviews and approves any courses that are not designated by an accrediting institution to meet the criteria for three hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

The committee also considered timely issues related to public health in the Commonwealth. Rice C. Leach, MD, Commissioner of Public Health, reported on a number of important legislative matters, including the recommendation from the Prescription Drug Task Force for a special prescription form for controlled substances. He also stressed the Cabinet's desire to work with communities to coordinate care and reported that CHS had recently given $7,000 to the KMA Alliance "Hands Are Not for Hitting" project.

Clarkson Palmer, MD, Manager, CHS Communicable Disease Branch, reported on the development and implementation of Kentucky's Statewide Immunization Information System. The Registry was started in 1994 in the Health Departments and has helped increase the percentage of two-year-olds receiving their vaccines from 65% to 90%.

Sandra Gambescia, manager of Kentucky's program, was manager of the Arizona Central Registry in which all physicians had access to the immunization records for children. This helped to eliminate duplicate immunizations and keep physicians aware of immunization needs of their patients. The committee agreed that a more accurate, easily accessible registry is needed in Kentucky and hopes that more state funding will enable the immunization registry development to continue in its progress.

The committee agreed to work in conjunction with the CHS Division of Substance Abuse, under a grant to fund the Kentucky Youth Substance Abuse Prevention Project, on a project to survey every primary care physician in the state on their efforts to: 1) ask every teen and adult patient if they smoke or use tobacco in any form, and 2) where affirmative, advise the patient to stop smoking and/or using tobacco.

The committee will continue to pursue these current issues and will consider additional health and safety issues in the coming year. The members of the Community and Rural Health Committee and Subcommittee on Domestic Violence would like to thank the Board of Trustees for being permitted to serve.

Baretta R. Casey, MD
Chair

Report of the Committee on Physical Education and Medical Aspects of Sports

The Committee on Physical Education and Medical Aspects of Sports advises the Kentucky Department of Education and physicians in the state on programs that result in the development of stronger, healthier bodies in youths, and conducts seminars throughout the state to promote healthy training for high school athletes.

This year the committee reviewed draft programs for 19 sports medicine symposia throughout the state, scheduled between April and September. Two programs were not approved because they failed to meet development and curricula criteria.

Seminars are directed primarily to high school athletic coaches and athletic trainers. Institutions wishing to conduct seminars must follow a program format developed by the committee that includes the following requirements:

- sponsors must be Kentucky-licensed physicians
- attendees must be annually certified for CPR
- subject matter must be reviewed prior to the printing of programs
- qualified speakers must be used
- content must not be repetitive
- symposia dates and sites must not conflict with other seminars

Subject matter must include sports conditioning; information on preparticipation examinations; use of protective equipment; soft tissue and skeletal injuries; taping, bracing, and field treatment of muscular/skeletal injuries; management of medical disorders; treatment of neurological injuries; rehabilitation of injuries; nutrition; use and abuse of drugs, and other items. In addition to developing the programs, sponsors must conduct a post-seminar survey and monitor attendance.

In review of the program content for seminars, it was noted that some sponsors had included lectures on creatine supplementation. In the collective knowledge of the committee members, creatine supplementation has not been subjected to valid, double blind studies. While the committee did not feel it was appropriate to take positions on specific scientific matters as such, it was agreed to advise all program sponsors that the current medical literature has not clearly defined the potential risks of creatine ingestion. Because some information suggestions that creatine supplementation may lead to electrolyte imbalance and dehydration, physicians should ensure that accurate information is presented if the issue of creatine supplementation is discussed in the symposia.

All coaches and athletic trainers are required to complete a seminar periodically, and there has been some ongoing concern on the part of participants about the frequency of required attendance. Concern has also been expressed by participants about the redundancy of the material, although the Department of Education and the Kentucky High School Athletic Association feel there is sufficient turnover in coaches and athletic directors, as well as the emergence of new information, to warrant this repetition.

However, in response to these concerns, the committee formed an ad hoc committee, which includes program coordinators and trainers who participate, to review the content of these programs and to see if they should be focused on specific sports. The work of this ad hoc committee is still in progress.

This year the committee considered the issue of minimal weight requirement for high school wrestlers. Problems have arisen when athletes in a given sport have taken extraordinary measures to accomplish weight reduction in order to qualify for the lightest weight classes possible for wrestling competition. This matter has received national attention because of three deaths that were reported to the National Collegiate Athletic Association. This situation presents an obvious dilemma to wrestling coaches, and the Kentucky High School Athletic Association representative confirmed the importance of the committee's assistance. To this end, another ad hoc committee was formed to develop recommendations. The work of this group is also still in progress.

In past years the committee worked to gain development and approval of a standardized form for school athletic participation medical examinations. This form is important because it would help standardize quality and could be used as a tool to help ensure that all necessary information becomes a part of the student's record.

With the creation of local site-based councils under KERA, there is a technical prohibition of imposition of forms, although many systems use standardized forms traditionally. This committee developed the portions of the current form relating to medical information, and the committee recommended to the Kentucky Athletic Association and the Department of Education that all efforts be made to continue the use of these forms.

As the chairman of the committee, I continue to be impressed and humbled by the dedication and loyalty the members unselfishly provide to the committee's work and to the betterment of our school-age children and their welfare.

R. Quin Bailey, MD
Chair

Report of the Committee on Child and School Health

The Committee on Child and School Health is responsible for issues relating to quality medical care for Kentucky's children. The committee is charged to advise the Board of Trustees and House of Delegates on issues relating to children's health. This year the committee continued its oversight on a number

of ongoing matters and considered some new issues.

For some time, the committee has been working with the Kentucky Department of Education on the "Adopt-A-Physician" program. In this program committees are matched with local physicians who act as consultants on a broad range of health issues. Letters to Kentucky school superintendents were finalized by the Education Department and sent to local site-based groups, and letters were finalized and mailed to participating physicians in December. A total of 106 physicians have been matched with 51 school districts to provide consultation. The committee is involved in attempting to identify funding sources for the purchase of medical books recommended by local physicians. The committee intends to send a brief questionnaire to participating physicians after the program has been in operation for some months to determine their impressions.

The committee considered the new federally legislated insurance program for uninsured children, which has become known as the Kentucky Children's Health Insurance Program (K-CHIP). An informal group had been working for some time and later gained more formal status from the Governor's office to develop plans to implement this program. Federal funds are provided in conjunction with state matching funds to provide coverage for children who are not eligible for Medicaid. Before federal funds can be expended, state matching funds must be committed and an implementation program developed along federal guidelines. KMA and the committee were well represented in this state effort through Thomas L. Young, MD, one of the committee members who was part of the informal work group. A broad outline plan was developed and passed by the Kentucky Legislature, and the Board of Trustees has assigned to this Committee the task of monitoring implementation of the program. We gladly accept this responsibility and will lean heavily on Dr Young's input.

The Kentucky Coalition for School Health is an independent, multidisciplinary coalition of individuals which acts as a liaison with other public and private organizations for the exchange of information regarding all phases of school health and conducts school health educational workshops. Among its members is the Kentucky Chapter of the American Academy of Pediatrics. After discussion, it was felt that it was appropriate for KMA to become a member of the coalition with this committee acting as the representative focus. Upon request to the Board of Trustees, this membership was approved and participation with the group will take place through the person of the chairman and Lisa C. Verderber, MD, of Louisville.

Along similar lines, the committee considered a pamphlet developed by the Kentucky Pediatric Society entitled The Dirty Dozen, which outlines safety hazards finally found on playgrounds. The committee continues to consider ways to work with the Kentucky Pediatric Society to disseminate this brochure to schools and students.

Following previous discussions, the committee obtained information on administration of medications in the school setting from the Tennessee Department of Education. This material related to guidelines used in that state for dispensing medication to students during school hours. Problems have arisen in Kentucky where students and other school personnel were reluctant or incapable of providing some of the medications and quasi treatments that some children required, and the committee was sensitive to liability, as well as medical care, issues. The Tennessee effort, which included input from the Tennessee Department of Education, Tennessee Educational Association, and the medical association, resulted in legislation and implementing regulations that seemed an appropriate address of the issue. The committee will continue to work with the Kentucky Educational Association and the Kentucky Department of Education on this matter.

Resolution 97-113, adopted by the KMA House of Delegates in September 1997, related to high school start times. This resolution was referred by the Board of Trustees, which called on this committee to study the impact of early high school start times on health and education in Kentucky and develop a recommendation with regard to it. The committee reviewed voluminous material, including scientific studies pertinent to the resolution that had been provided by the resolution's author, a Lexington physician. Other similar information reviewed was obtained from the medical societies in Wisconsin and Minnesota.

After significant consideration, the committee developed a statement which concluded that scientific information exists which substantiates the negative effects of sleep deprivation on adolescents, but it is not within the purview of this Association to resolve the issue given all of the nonmedical issues that pertain. This recommendation was forwarded to the Board of Trustees, which accepted it.

This year the committee was designated by the Board of Trustees to monitor and represent KMA with the Cabinet for Health and Human Services Division of Substance Abuse and Prevention regarding a federal grant. Kentucky is one of five states that are recipients of incentive grants to combat substance abuse through prevention programs. A representative of the committee will serve on an advisory council, which will oversee use of these grant monies through the office of the governor. This is an ongoing effort that will require the committee's continued involvement. More information will be reported as efforts develop.

As chairman, it has been my pleasure to work with the active, energetic, and interested members of the committee, and I would like to thank them for all of their efforts.

Thomas H. Pinkstaff, MD
Chair

Report of the Judicial Council

The KMA Judicial Council conducted no formal meetings during the past year. There were no reported investigations and no local trustees were called upon by the council to investigate matters in their districts. Various inquiries from physicians were received throughout the year regarding their rights and responsibilities under various areas of the law. To help physicians stay informed on such issues, KMA decided to make such information available in the form of a legal handbook. This handbook will hopefully be provided to the membership later in the year.

The KMA House of Delegates passed Resolution 133, which called for the Kentucky Board of Medical Licensure and the Judicial Council to address the issue of so-called "gag clauses" in physician contracts. The Board of Medical Licensure met during the past year and ruled that it would be unethical for physicians to abide by such agreements. The KMA also pushed Patient Protection Legislation through the legislature, which included a ban on such contract clauses. Any further action by the council on this issue would have been duplicative, as the efforts of the Licensure Board and the Committee on State Legislative Activities seem to have addressed the issue.

The council is honored to serve the Association and urges all KMA members to follow their recognized professional responsibilities and obligations, as well as educate themselves on such matters.

William P. VonderHaar, MD
Chair

Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan

While the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan did not meet this year, we continued to press for adoption of legislation to require that health education be taught in all schools K-12. The KMA House of Delegates has consistently recommended that health education be taught to all students from kindergarten to 12th grade and has affirmed support for "parenting and family life skills education" curriculum in public schools. In addition, the House of Delegates has urged the adoption of a curriculum that includes sex education in schools, beginning in grades 5-7, in recognition of the fact that Kentucky has a very difficult and major problem with young adolescent pregnancies. The KMA also encourages uniform health education and physical fitness proficiency testing in all schools.

The ad hoc committee has involved itself with the development of a comprehensive school health education plan of which parenting and family life skills are a facet. The committee is hopeful that recommendations will eventually be seriously considered by the Kentucky General Assembly.

Due to blistering and unrelenting attack upon the Kentucky Education Reform Act (KERA), supporters of the KMA position have been reluctant to sponsor or at least strongly back the mandatory health education provision. Even within the ranks of the medical profession there is sharp division, especially in the area of sex education. Presently, the political climate does not exist to enact the KMA proposal.

During the 1998 Kentucky General Assembly, your Chair and other physicians and KMA lobbying staff met with the Chairs of the Education Commit-

tees to discuss this issue. While sympathetic to our position, it was obvious that the 1998 Kentucky General Assembly simply did not want to deal with this issue.

Despite our inability to obtain broad support for our position, we will continue our efforts. On behalf of members of the committee we appreciate the opportunity to support our patients, the profession, and especially the future generation of this Commonwealth, our children.

Thomas L. Young, MD
Chair

Report of the Ad Hoc Committee to Recommend a Section on International Medical Graduates

The Ad Hoc Committee on International Medical Graduates was formed to develop recommendations for the Board of Trustees to consider as to whether or not a KMA section on International Medical Graduates should be formed.

The genesis of our committee was resolution 97-121. The committee initially developed the following basic points:

- KMA's goal is to achieve active participation by all physicians, regardless of what subcategories they may fall into. The creation of subgroups might enhance a sense of separation, rather than promote unity.
- Any subsection of KMA that is formed should have as its intent to increase participation/membership and to identify and deal with specific needs that are not otherwise addressed by KMA.
- Some of the concerns of international medical graduates may not be within the scope of address of KMA, such as visa difficulties, the number of IMGs in residency positions, and so forth.

The committee noted that IMG membership in KMA is proportional to US graduate membership statewide. However, international medical graduates may have unique concerns that could be addressed.

A survey of international medical graduates in the state (1,241 physicians) was conducted to try to determine unmet needs. The committee sent 1,241 surveys and received 227 responses, for an 18% response rate. Of 723 IMG members, 191 responded (26%), and of 519 IMG nonmembers, 36 responded (7%).

Most members responded that they joined KMA for representation, benefits, and services. Nonmembers that responded said they would join KMA if it worked to stop discrimination, ensure fair treatment, and if an IMG section were formed.

Among IMG members responding, 80% said that KMA services met their needs, while 15% said they did not. Among IMG nonmembers responding, 36% (13) said KMA met their needs, and 39% (14) said it did not.

Member and nonmember IMGs listed social alienation, professional discrimination, cultural adjustment, and the need for a "better" licensing process, as unique IMG needs.

When asked directly if KMA should form an IMG section, 46% of members said "yes," 43% said "no," and 12% had no opinion. Of nonmembers, 44% said "yes," 47% said "no," and 8% had no opinion.

The committee felt that the results of the survey were ambiguous. All respondents claimed that their interest in KMA was because of representation, services, and benefits. This correlates with other surveys recently conducted by KMA. All respondents indicated the same special needs of IMGs whether members or not.

Meredith J. Evans, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Interspecialty Council

The Interspecialty Council did not meet this year. The Board of Trustees reactivated the council in 1996 in order to promote and improve communications between KMA and the organized medical specialty groups in Kentucky.

Although the council met on two occasions since its appointment, there has been very little participation on the part of individual specialty societies. Because of this, it was felt that a needs assessment survey should be done to determine the future direction of the council and what medical and socioeconomic issues would be of interest in this effort.

Twenty-six specialty group representatives were surveyed in April on issues of importance to the future of medicine and the usefulness of the council in addressing these areas for the benefit of the federation of medicine. About one-third of the specialty groups responded to the questionnaire and subsequent follow-up mailings.

Robert R. Goodin, MD
Chair

RECOMMENDATION:

1. Because of the small response and inadequate representation at previous meetings, it is recommended that the Interspecialty Council not be reappointed by the Board of Trustees for the 1998-1999 Associational year.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E next considered the Report of the Interspecialty Council and its Recommendation, that due to the small response and inadequate representation at previous meetings, the Interspecialty Council should not be reappointed by the Board of Trustees for the 1998-1999 Association year.

Reference Committee E recommends that Report No. 40 and its Recommendation be adopted.

RESOLUTION 98-103

Medicaid Outpatient Testing
Jefferson County Medical Society

WHEREAS, Kentucky Medicaid requires physician-patient contact on the same day certain referred, noninvasive diagnostic procedures are performed if the physician is to be reimbursed for professional-technical services; and

WHEREAS, it is often a medically unnecessary requirement that in order to be reimbursed, a physician must see the patient on the same day referred outpatient diagnostic tests are performed, such as EEG, echocardiogram, EKG, visual field testing, outpatient radiological services, ultrasound, etc; and

WHEREAS, this requirement forces many physicians to refer patients to hospitals for diagnostic testing, where the same requirement for physician-patient contact does not apply; and

WHEREAS, the requirement for physician-patient contact results in increased cost to the system, inconvenience for patients, and restricted access for outpatient testing; now, therefore, be it

RESOLVED, that KMA seek the establishment by Medicaid and/or the Regional Medicaid Provider Partnerships of a single accepted standard of care and a single reimbursement mechanism applicable to professional-technical services related to noninvasive outpatient testing, regardless of whether such testing is performed in a physician's office, an outpatient center, or at a hospital.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E reviewed Resolution 103, Medicaid Outpatient Testing, submitted by the Jefferson County Medical Society. There was some discussion among committee members as to the applicability of this issue to Medicaid providers but it was felt that the intent was appropriate and important. Reference Committee E recommends that Resolution 103 be adopted.

After considerable discussion, an amendment was offered from the floor of the House, to read:

RESOLVED, that KMA ~~seek the establishment~~ request physician reimbursement by Medicaid and/or the Regional Medicaid Provider Partnerships ~~of a single accepted standard of care and a single reimbursement mechanism applicable to~~ for professional-technical services related to noninvasive outpatient testing, regardless of ~~whether~~ where such testing is performed ~~in a physician's office, an outpatient center, or at a hospital.~~

Resolution 103 was adopted as amended on the floor of the House.

RESOLUTION 98-110

Confined Animal Feeding Operations (CAFOs)
John A. Patterson, MD, MSPH

WHEREAS, a Kentucky agriculture heavily dependent on tobacco is at a critical juncture searching for diversification alternatives; and

WHEREAS, some agriculture entrepreneurs and members of Kentucky's agriculture leadership believe large-scale confined animal feeding operations (CAFOs) are "the future" of Kentucky livestock production; and

WHEREAS, many Kentucky small farmers oppose this corporatization of Kentucky agriculture and granting of tax incentives to them, and the Community Farm Alliance (a group of small family farmers) has joined the Sierra Club (representing Kentucky's environmental community) in a legal challenge to one such CAFO; and

WHEREAS, the state health officer of North Carolina (Dr Dennis McBride) has recently called for an extension of that state's current moratorium on construction of CAFOs in North Carolina after a survey of private water wells showed 10% contained dangerous levels of nitrates (responsible for methemoglobinemia/blue-baby syndrome) which could be caused by inadequate handling of hog and chicken manure from CAFOS; and

WHEREAS, the *Lancet* recently published an article establishing a connection between human neurologic and dermatologic disorders and exposure to Pfiesteria piscicida and related dinoflagellates, organisms whose presence in waterways is believed related to manure runoff from CAFOs and which led to massive fish kills in North Carolina; and

WHEREAS, the 1997 KMA House of Delegates considered a resolution concerning large-scale hog farms in Kentucky and the KMA Board voted to send a letter to the Governor endorsing his action to suspend the issuance of permits for new commercial swine operations; and

WHEREAS, 1) Kentucky's Environmental Quality Commission has previously called for the establishment of a Blue Ribbon Panel to consider state regulation of CAFOs; 2) no such panel has been established; 3) temporary emergency regulations are in place covering factory hog farms, but the regulation of factory chicken farms is currently in limbo; 4) Kentucky's General Assembly came close to passing legislation that would significantly weaken emergency regulations passed by the Governor and the Natural Resources Secretary; and 5) the legislature will have an opportunity in the next session to consider weakening them again; and

WHEREAS, the Governor's 23rd Annual Conference on Environment scheduled for October 27 and 28 will focus on water supply planning and protection with special emphasis on CAFOs; and

WHEREAS, KMA's designated representative to Partners for Family Farms meets monthly with the Health and Agriculture Forum and regularly with the no-name working group (comprised of agriculture and environmental representatives) and maintains constant vigilance on this and related health and agriculture issues; now, therefore, be it

RESOLVED, that KMA express to the Governor and Natural Resources Secretary concern over the potential adverse public health impact of CAFOs; and be it further

RESOLVED, that KMA once again urge the Governor to establish a Blue Ribbon Panel to study the regulation of confined animal feeding operations (CAFOs) and that such a panel include representatives from agriculture, public health, the environmental community, and local and state governmental regulatory agencies.

RECOMMENDATIONS, REFERENCE COMMITTEE E:
Reference Committee E next considered Resolution 110, Confined Animal Feeding Operations (CAFOs), submitted by John A. Patterson, MD, MSPH.

After considerable discussion among committee members, members of the Board of Trustees, and public health officials, it was determined that insufficient information was presented for Reference Committee E to make a judgement on this resolution. Reference Committee E recommends Resolution 110 be referred to the Board of Trustees.

RESOLUTION 98-122

Vaccine for Children (VFC)
Board of Trustees
WHEREAS, Section 1928 of the Social Security Act established the Vaccine for Children (VFC) program and was enacted as part of OBRA 1993; and

WHEREAS, the purpose of the program was to provide access for children to all immunizations specified by the Center for Disease Control's Advisory Committee on Immunization Practices; and

WHEREAS, the VFC program entitles certain children to receive federally purchased, qualified pediatric vaccines and requires that as a condition of Medicaid participation, states establish a program of vaccine distribution to physicians and other providers who administer the vaccines to "vaccine eligible" children; and

WHEREAS, a "vaccine eligible" child is defined to mean a Medicaid-eligible child, a child who is not insured, a child who is administered a qualified pediatric vaccine by a federally qualified health center or a rural health clinic and is not insured with respect to the vaccine, or a child who is an American Indian; and

WHEREAS, the Health Care Financing Administration (HCFA) has determined that children covered by a State Children's Health Insurance Program (S-CHIP) are not eligible for VFC; and

WHEREAS, the 1998 Kentucky General Assembly has adopted the Kentucky Children's Health Insurance Program (K-CHIP); now, therefore, be it

RESOLVED, that the KMA urge Congress to amend existing federal law to make children covered by a State Children's Health Insurance Program eligible for Vaccine for Children (VFC); and be it further

RESOLVED, that KMA support S 2013, HR 3794, and other similar legislation that would allow states operating a State Children's Health Insurance Program to provide subsidized immunizations as a benefit to children.

RECOMMENDATIONS, REFERENCE COMMITTEE E:
Reference Committee E next considered Resolution 122, Vaccine for Children (VFC), submitted by the Board of Trustees. There was considerable discussion on this resolution. The Committee heard testimony from Rice Leach, MD, Commissioner, Department for Health Services; John Morse, Secretary, Cabinet for Health Services; and several Kentucky pediatricians on this resolution, as well as Resolution 123.

Reference Committee E recommends that Resolution 122 be adopted.

RESOLUTION 98-123

Universal Vaccine
Board of Trustees
WHEREAS, several states have been designated "Universal Vaccine" states, whereby all childhood vaccines are provided by the state for the immunization of all children; and

WHEREAS, the Universal Vaccine Program is a federal/state effort which requires singular fiscal and state administrative commitments; and

WHEREAS, currently there is no single coordinated method to assure comprehensive vaccine availability; now, therefore, be it

RESOLVED, that KMA explore the feasibility of pursuing implementation of the Universal Vaccine program in Kentucky.

RECOMMENDATIONS, REFERENCE COMMITTEE E:
Reference Committee E next considered Resolution 123, Universal Vaccine, submitted by Board of Trustees. Based on testimony, the committee felt that implementation of this program would be preferable to that proposed by Resolution 122. However, information available suggested that accomplishment of the Universal Vaccine Program was less likely to be achieved than the VFC. Regardless, Reference Committee E recommends that Resolution 123 be adopted.

Mr Speaker, Reference Committee E recommends the adoption of the report of Reference Committee E as a whole, as amended.

Mr Speaker, I would like to thank the other members of this committee—Daniel E. Kenady, MD, Lexington; William P. McElwain, MD, Mt. Vernon; Barbara A. Phillips, MD, Lexington; LaDonya Reed, Lexington (MSS); and Scott B. Scutchfield, MD, Danville—for their time and thoughtful consideration of the issues referred to the reference committee. The Chair would also like to thank Teresa Harper for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE E
John S. Cave, MD, Henderson, Chair
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Barbara A. Phillips, MD, Lexington
LaDonya Reed, Lexington (MSS)
Scott B. Scutchfield, MD, Danville

Greg Cooper, MD, Board of Trustees Chair, advised the House about a recent announcement made by Anthem Blue Cross and Blue Shield concerning the establishment of a hospital-exclusive network for cardiac care. He reported that the Board has directed the Quick Action Committee to meet with Anthem to discuss this, and the membership will be kept informed.

Dr Cooper then made a motion on behalf of the Board to appoint Paul R. Smith, MD, London, to the KMA Judicial Council. Dr Smith was nominated to replace William T. Watkins, MD, whose term had expired. Dr Cooper expressed appreciation to Dr Watkins for his service. Dr Smith was appointed by acclamation.

Election of Officers

Susan Berberich, MD, Chair of the Nominating Committee, presented the slate of nominees for offices, as follows:

President-Elect	Harry W. Carloss, MD, Paducah

Dr Carloss was elected by acclamation, and was escorted to the podium by Past Presidents Wally O. Montgomery, MD, and Robert R. Goodin, MD. The following nominees were also elected by acclamation:

Vice President	Donald R. Neel, MD, Owensboro
Speaker (2001)	John W. McClellan, MD, Henderson
Vice Speaker (2001)	Thomas K. Slabaugh, MD, Lexington
Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Robert R. Goodin, MD, Louisville
Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Wally O. Montgomery, MD, Paducah
Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Donald J. Swikert, MD, Florence
Alternate Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Bob M. DeWeese, MD, Louisville
Alternate Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Preston P. Nunnelley, MD, Lexington
Alternate Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	William B. Monnig, MD, Edgewood

Dr Berberich then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

1st District Trustee	Robert C. Hughes, MD, Murray
1st District Alternate	Carolyn S. Watson, MD, Paducah
3rd District Trustee	Uday V. Dave, MD, Madisonville
3th District Alternate	C. R. Dodds, MD, Earlington
12th District Trustee	Donald E. Brown, MD, Somerset
12th District Alternate	David C. Liebschutz, MD, Danville
14th District Trustee	Baretta R. Casey, MD, Pikeville
14th District Alternate	Charles G. Nichols, MD, Pikeville

Election of 1999 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1999 KMA Nominating Committee:

Barbara A. Phillips, MD, Lexington, Chair
David E. Bybee, MD, Louisville
Linda Mumford, MD, Owensboro
J. Roger Potter, MD, Ashland
Scott A. Watkins, MD, Henderson

Newly installed KMA President Donald R. Stephens, MD, was called to the podium and made some brief remarks.

Speaker McClellan adjourned the 1998 Session of the KMA House of Delegates at 9:25 PM.

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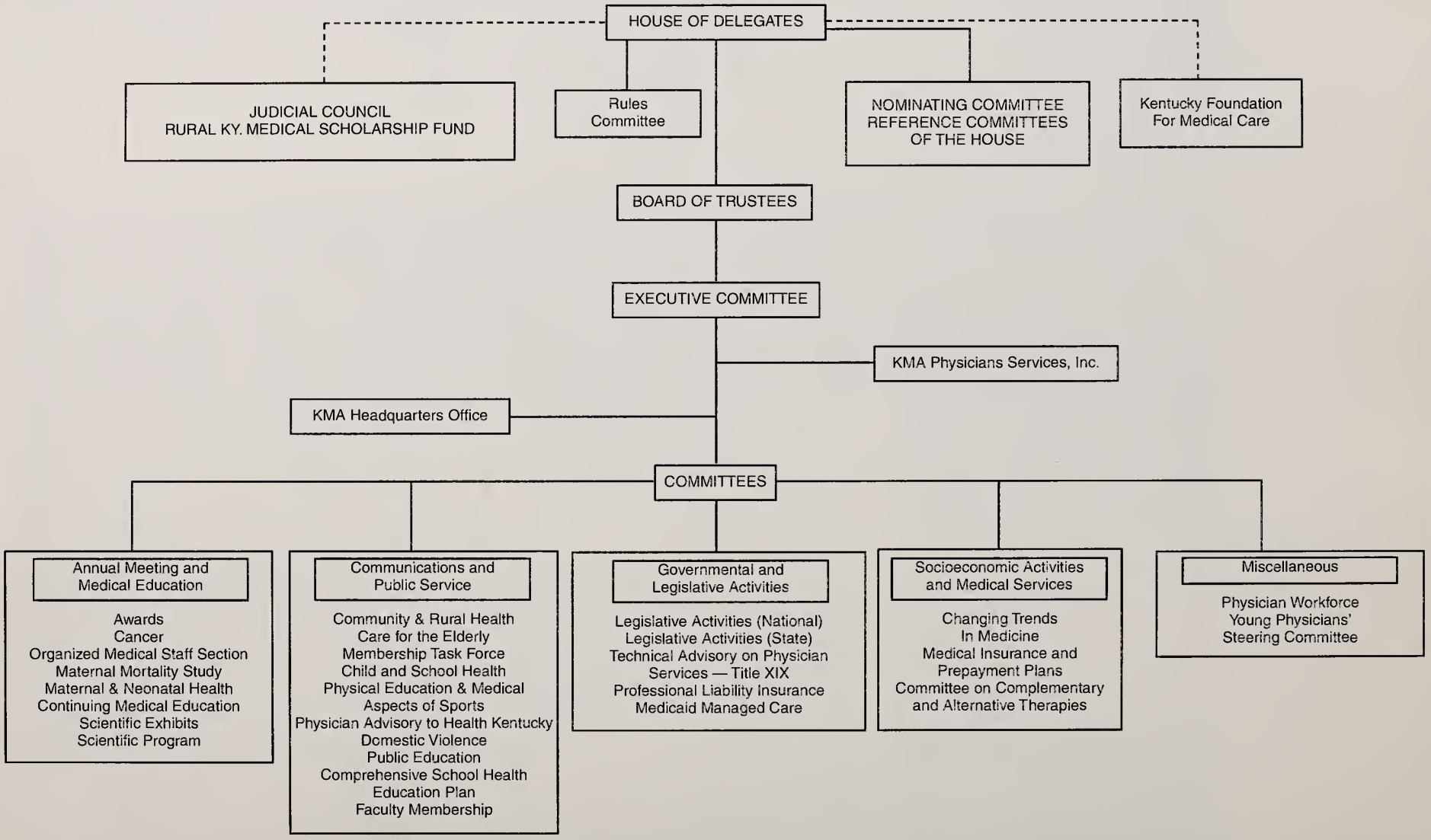
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Cumulative Index

The Journal of the Kentucky Medical Association

Volume 96 — 1998

Month	Pages
January	1 to 36
February	37 to 84
March	85 to 124
April	125 to 164
May	165 to 208
June	209 to 244
July	245 to 280
August	281 to 344
September	345 to 388
October	389 to 428
November	429 to 472
December	473 to 576

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SCIENTIFIC ARTICLES

A

Adnexal Torsion, 486
Airway Resistance Syndrome, Upper, 261
Anorexia and Failure to Grow Associated with Epstein-Barr Virus Infection, 13
Arthritis With Fluconazole Monotherapy, Treatment and Cryptococcal, 449

B

Bone Marrow, Gelatinous Transformation of, 10

D

Dysphagia, Symptoms, Diagnosis, and Management, 362

E

Endobronchial Malignancy, Bronchial Foreign Bodies Simulating, 226

H

Heart Surgery, Risks of Cerebrovascular Events Related to Open, 290
Histoplasmosis: Progressive Pneumonia Resulting from High Inoculum Exposure, Acute Pulmonary, 258

M

Melanoma of the Head and Neck (Grand Rounds), Diagnosis and Treatment of Cutaneous, 46

P

Primary Care Rounds—"The Middle-Aged Golfer," 59
Puberty: When it Comes Too Soon, 441
Pulmonary Function Testing: Detection of Invalid Performance, 183

R

Radiograph in the Detection of Pericardial Effusion: A Reevaluation, The Lateral Chest, 218
Rhabdomyosarcoma in Children—A Ten Year Review, 399

S

Snake Bite of a Child, Venomous, 56
Sporotrichosis: Efficacy of Oral Itraconazole, Chronic Cavitary Pulmonary, 103

W

Wallenberg's Syndrome: A Case Report, Spontaneous Vertebral Artery Dissection Resulting in, 140

SCIENTIFIC AUTHORS

A

Aronoff, George R, MD, FACP, 449
Attum, Abdulla A, MD, 290

B

Baker, Barbara M, PhD, 362
Barbie, Ronald, MD, 290
Berry, David T R, MD, 183
Bertolone, Salvatore J, MD, 399
Bradford, William B, MD, 399
Butler, David, MD, 399
Byrd, Ryland P, Jr, MD, 103

C

Charnvitayapong, Kasem, MD, 226
Clark, Pamela A, MD, 441

D

David, Craig C, MD, 59

F

Fletcher, Eugene C, MD, 226, 261

G

Girardet, Roland, MD, 290

H

Hasan, Nuzhat, MD, 261
Hymes, William A, MD, 226, 290

J

Jose, B Oliapuram, MD, FACR, 399

K

Kar, Pran M, MD, FACP, 449
Kloecker, Goetz Hans, MD, 140

L

Lansing, Allan, MD, PhD, 290
Lee, Frank, MD, 449
Lindberg, Robert D, MD, FACR, 399

M

Matthew, Thomas, MD, 290
McKinney, W Paul, MD, 258
McMasters, Kelly, MD, PhD, 46
Meals, Lee Tolar, MD, 258
Miller, Daniel L, MD, 226

P

Paris, Kristie, MD, 399

Patel, C C, MD, 399
Phillips, Barbara A, MD, MSPH, 183
Polk, Hiram C, Jr, MD, 46

R

Raleigh, Dennis, MD, 290
Ramirez, Jesus, MD, 103
Raphael, Bernd, MD, 140
Roy, Thomas M, MD, 103

S

Schuldheisz, Sandra, MD, 183
Sheikh, Hamid H, MD, 486
Spanos, William J, Jr, MD, FACR, 399
Shultz, Alan, MD, 10
Simon, Michael, MD, PhD, 13, 56
Stadelmann, Wayne K, MD, 46

W

Woodring, John H, MD, 218

Y

Yam, Lung T, MD, 10
Yared, Sam, MD, 290

SPECIAL ARTICLES

Child Restraint Law Has Saved Lives: A 20-Year Review of Fatalities Among Children (Aged 0-4) as Motor Vehicle Occupants, Kentucky's, 97
Cigarette Smoking in Kentucky: Smoking-Attribute Mortality and Years of Potential Life Lost, 451
Fatalities, 1994–1996, Potentially Productive Years of Life Lost (PPYLL) in Kentucky Due to Occupational, 369
Financial Planning Considerations at Retirement, 106
Kentucky Physicians' Perspectives and Prepardeness for Computing in Medical Education and Practice, 405
Mammography Screening: The James Graham Brown Cancer Center Three Year Experience—Implicaitons for Public and Professional Education, Mobile, 17
Maternal Mortality in Kentucky, 135
Medical School Applicants Will Become Generalists or Rural-Based Physicians?, Which, 189
Pleural Space, New Technology in Diagnosis and Treatment of Diseases of the, 174
Politics, Kentucky Physicians and, 357
Thrombosis Prophylaxis After Total Hip & Total Knee Arthroplasty: A Cost Comparison, Warfarin Vs Enoxaparin for Deep Venous, 143
Uninsured Indigents: The Perspective of Providers in the Kentucky Physicians Care Program, Health Care for Kentucky's, 231

SPECIAL ARTICLES AUTHORS

Amin, Elizabeth A, MD, 17
Blondell, Richard D, MD 189
Blue, Amy V, PhD, 405
Bonaminio, Guilia, PhD, 405
Carrillo, Eddy H, MD, 174
Cole, Robert J, Jr, CLU, ChFC, CFP, 106
Fitzgerald, Diane, 405
Flynn, Michael B, MD, 17
Gagel, Janice R, MSN, 189
Garcia-Zozaya, Inigo, MD, 143
Goldstein, L A, PhD, 97
Greene, John W, MD, 135
Griffith, Charles H, III, MD, MSPH, 231
Linker, Robert W, MD, 174
Looney, Stephen W, PhD, 189
Mainous, Arch G, III, PhD, 231
Martin, Robert C G, II, MD, 17
McCown, L Joyce, 231
Miller, Frank C, MD, 135
Monnig, William B, MD 357
Moon, Ellyn, MA, 369
Nora, Lois Margaret, MD, JD, 405
Palmer, Clarkson T, MD, MPH, 451
Pentecost, Margaret W, MAT, 189
Petry, John A, MD, 135
Ramsbottom-Lucier, Mary, MD, 405
Richardson, J David, MD, 174
Rubeck, Robert, PhD, 405
Scheerer, Amy, MSPH, 369
Struttman, Tim W, MSPH, 369
Spurlock, C W, PhD, 97
Stapleton, Margaret P, MSPH, 451
VonderHaar, William P, MD, 357
Witzke, Donald, PhD, 405

MEDICO-LEGAL

Contracts That Can Bring Trouble to Physicians, Dealing With "Excluded Providers;", 457
Tax-Exempt Healthcare Organizations Can Be Hazardous to One's Financial Health, PHYSICIANS BEWARE! Dealing With, 65
The Latest Word on Confidentiality of Peer Review, 491

MEDICO-LEGAL AUTHORS

Cronan, Charles J, IV, 491
Padgett, Patrick T, 457
Seiffert, James C, Esq, 65

SPECIAL FEATURES

Delegate Roll Call, 518
Digest of Proceedings, 1998 House of Delegates, 521
Index to Proceedings & Reports, 522
Index to Resolutions, 523
Index of Journal Volume 96—1998, 571
KMA Committees, 567
KMA Organization Chart, 570
KMA Reference Committees, 524

ASSOCIATION NEWS

A

AMA Article—Physician Impairment and Health: A Brief Overview, by Larry S. Goldman, MD, 25
AMA Elects Three Kentucky Leaders, 250
Annual Meeting, Keys to the City of Louisville—Your Host for the 1998 KMA, 254
Annual Meeting Preliminary Program, KMA, 301
Annual Meeting, 148th KMA, 504
Audits Underway, Fraud & Abuse, 201
Awards Nominations Form, KMA, 159, 188

B

Board of Trustees Spring Board Meeting, 238
Board of Trustees—December Meeting, KMA, 75
Board of Trustees Meeting, August, 420
Board of Trustees New Officer Profiles, KMA, 112

C

Carloss, MD, Nominated KMA President-Elect, Harry W, 199

D

Deceased Physicians, In Memoriam, 485
Dickey, MD, AMA President, Keynote Speaker, Nancy W, 273

E

Exhibit Guide, KMA Annual Meeting, 332
Exhibits Application, Scientific, 163, 182

H

House of Delegates 1997 Interim Meeting, Highlights of AMA, 114

L

Legislative Seminar, KMA 1998, 6

J

Journal Editors Honored by House of Delegates, 73

K

KEMPAC Political Seminar-Dinner, 300
Kmetz...and Welcomes Dr Joel Kaplan to Fill the Post, U of L Bids Farewell to Health Affairs VP Dr Donald, 379

M

Medicaid Managed Care, Committee on, 29
Member-Get-a-Member Campaign, KMA, 384, 425, 460
Monitoring Medicine, 7, 43, 91, 131, 171, 215, 251, 287, 353, 397, 437, 481

N

News, 30, 76, 117, 156, 200, 239, 274, 380, 422, 463

O

Officers' Profiles, 1997-98 New, 112

P

Physician's Recognition Awards, 466

R

Reference Committee G—AMA Annual Meeting, 28
Reference Committee on Amendments to Constitution & Bylaws—AMA Interim Meeting, December 1997, Actions of, 74

S

Stephens, MD, KMA President 1998-99, Profile—Donald R, 410

EDITORIALS

Assumptions, The Problem With, 149
Cult of Violence, The, 497
Drugstore, The, 195
Faithful Stewards...a Reflection, 415
Fear and Loathing at Fifty, 234
Hope, The Elixir of, 459
I've Had a Good Run!, 63
Just a Dot on the Line, 375
Privacy—Year 2000 and Beyond, Securing, 297
Provider—Not Me!, 269
Telemedicine, 109
Webster's New Edition, 21

EDITORIALS AUTHORS

Alumbaugh, Kimberly A, MD, 269
Burns, Carolyn D, MD, 21, 297
Miller, Milton F, MD, 63
Overstreet, A. Evan, MD, 195, 459
Smith, Stephen Z, MD, 109, 375
Stulc, Jaroslav P, MD, 234, 497
Varga, Daniel W, MD, 149, 415

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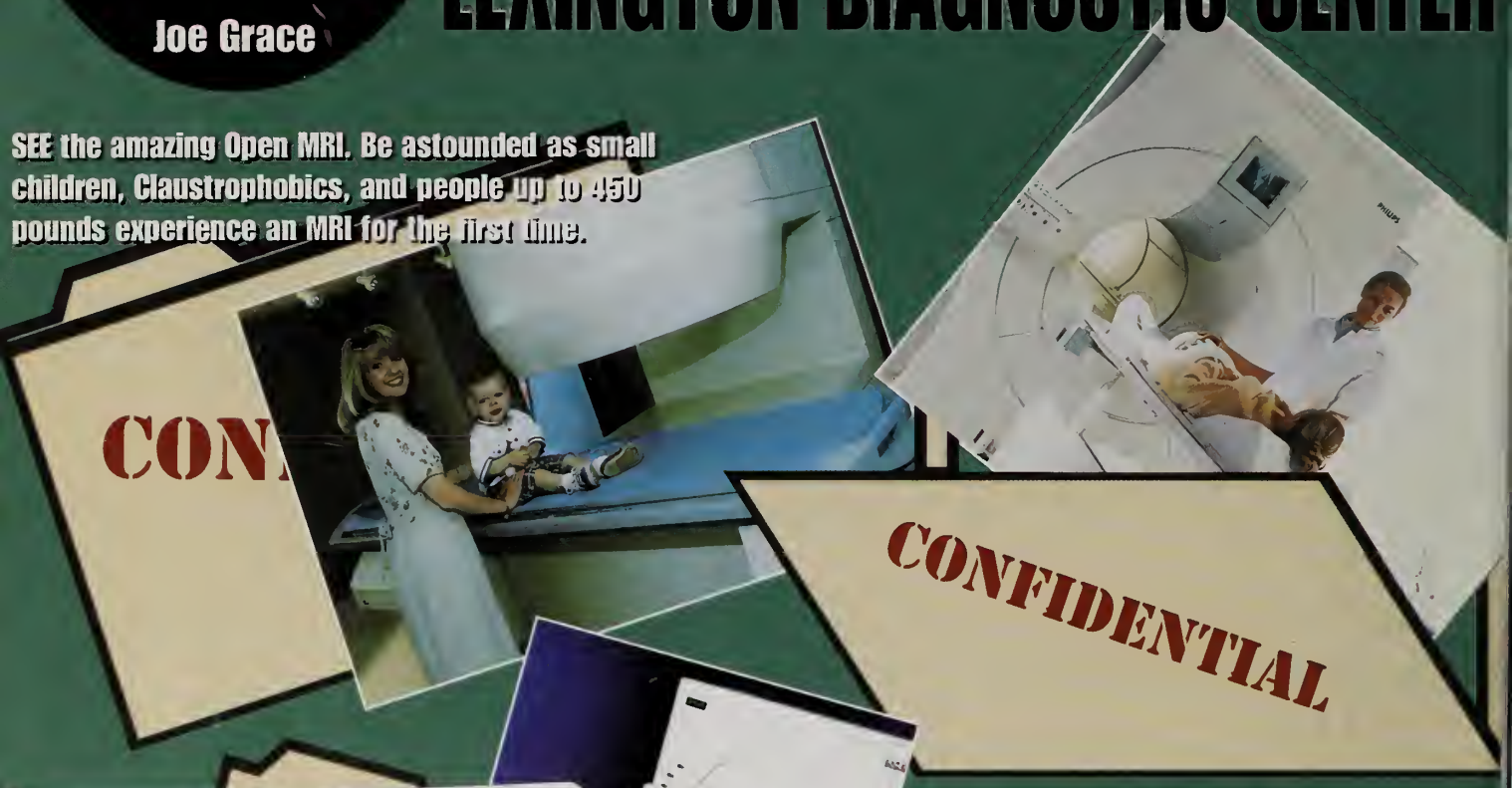
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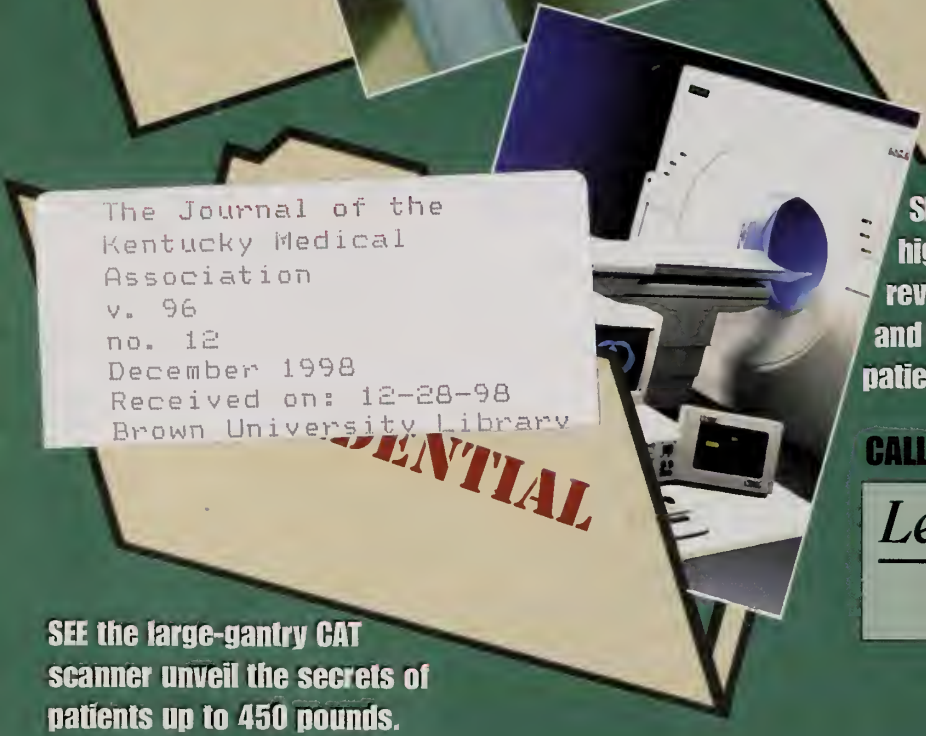
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